Maternal and Child Health Services
Title V Block Grant

State Narrative for Delaware

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

/2009/ Assurances and Certification Forms are kept on file in the State MCH program's office and can be made available by request to Alisa Olshefsky, M.P.H, Director of Maternal and Child Health or Walter Mateja, Title V Program Administrator. //2009//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2009/ Public input into the Title V application and Delaware's Maternal and Child Health (MCH) Services is an ongoing process sustained through a number of advisory committees, public forums, and other associated workgroups and ad-hoc committees. These processes are coordinated and integrated through the State's Maternal and Child Health Director and her staff under the direction of the Division of Public Health's Senior Executive Team and Strategic Planning initiatives. Drafts of the entire document, summaries of relevant parts of the document, and supporting reports and documentation are available upon request and are made available either electronically, in hard copy or through the World Wide Web. Each of the committees supporting MCH activities routinely holds public meetings, which are posted on the State's website. In addition, agendas and meeting minutes are also available either through the State website or upon request from the individual program manager.

The main committees which advise and review MCH activities include: the Delaware Healthy and Mothers Infants Consortium, a Governor appointed body with 5 working committees with wide ranging representation, including consumers; the Coordinating Council for Children with Disabilities; the Teen Pregnancy Prevention Advisory Board; the Early Comprehensive Childhood Systems Advisory Council; the Newborn Screening Advisory Council; the Newborn Hearing Advisory Council; the Traumatic Brain Injury Committee of the State Council for Children with Disabilities; and the Injury Prevention Coalition. Delaware actively solicits family involvement at health fairs and other events to participate on assorted Committees and planning bodies.

As part of its 2010 Needs Assessment, Delaware is actively seeking public input through two mechanisms. The first is the Education and Prevention Committee of the Delaware Healthy Mothers and Infants Consortium. This committee is responsible for reviewing activities related to education and prevention and ensuring materials and messages are consistent with the CDC's Recommendations for preconception health care. The committee meets monthly and has several consumers as active participants. The Coordinating Council for Children with Disabilities, an

advisory group for Children with Special Health Care Needs, will also be actively involved in needs assessment planning and interpretation of data. This group also has an active consumer involvement. Both of these groups can provide the resources for additional outreach to communities and the larger public throughout the state.

The state has also recently implemented a website, HealthyBabiesDe.com, which makes available assorted MCH related documents and reports. //2009//

/2010/ During the past year, as described in further detail in the Needs Assessment Section of this application, the MCH program has begun working on the five year needs assessment due with the application to be submitted in July 2010. As part of this process a committee was formed to examine priorities, strategies and needs for Delaware's Maternal and Child Health System. The committee consisted of family members of Children with Special Needs, representatives from community-based organizations, representatives from other state agencies, and representatives of assorted MCH Programs (WIC, SSDI, ECCS, Clinic-Based Services, Dental, Immunization, etc). Also during the past year, the MCH program began an initiative to establish an umbrella organization that would provide funding, technical support and one-stop shopping for family organizations concerned with Children with Special Health Care Needs issues throughout Delaware. A key informants interview process was completed and is discussed later in this application. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

The MCH Director and Child Health Director began working on the 5-year needs assessment early in 2008. The intent was to review, assess and re-vamp the MCH Block Grant to ensure the state performance measures were not duplicative of national measures and that they truly reflected state priorities. This new direction for the Block Grant was discussed at the 2008 Title V Block Grant review meeting with HRSA and with Dr. Hollinshead, formally the Rhode Island Title V Director. Dr. Hollinshead serves as the AMCHP mentor for Delaware's MCH Director who assumed the position in February 2008.

In order to truly understand the current impact of Title V funding and assess system-wide needs, a thorough census of services and programs by each level of the MCH pyramid was conducted. This MCH Matrix of Services (attachment to Overview Section) listed all direct health care, enabling, population-based and infrastructure building services that involved DPH staff or funding. A total of 43 initiatives were identified and examined based on target population, outcomes, evidence basis for operation and evaluation. Compiling the MCH Matrix of Services allowed the MCH Director to become intimately familiar with the breath and depth of MCH services available in the community, and to assess areas of duplication or opportunities for increased collaboration.

In summer 2008, an internal workgroup was established and trained on the CAST-V process. This workgroup was made up of key stakeholders in the areas of child health, newborn screening, newborn hearing, State Systems Development Initiative, Early Childhood Comprehensive Services, health promotion, communicable disease, public health clinics, adolescent health, reproductive health, nursing and management. In September 2008, the MCH Needs Assessment Workgroup was formally constituted. The MCH Needs Assessment Workgroup included the internal DPH workgroup along with parents, advocates, clinicians and children and youth with special health care needs (CYSHCN) organizations:

Community Organizations
- Children and Families First
- Coordinating Council for Children with Disabilities
- Family 2 Family
- March of Dimes
- Nemours Health and Prevention Services
- Family Representatives

Department of Services for Children, Youth and Their Families
- Office of Prevention and Early Intervention
- Division of Child Mental Health Services

Division of Publlic Health
- Disease Prevention and Health Promotion
- Emergency Medical Services for Children
- Health Information and Management
- Health Systems Management
- Immunizatons
- Adolescent and Reproductive Health
- Center for Family Health Research and Epidemiology

Child Development Watch
Newborn Hearing Screening
Early Childhood Comprehensive Systems
Newborn Metabolic Screening
Special Needs Alert Program
State Systems Development Initiative
Northern Health Services
Southern Health Services
Public Health Nursing
Smart Start/Kids KARE
Oral Health
WIC

Tools and strategies from HRSA MCHB, CDC and AMCHP were used to help identify state priorities. Over the course of six months, the MCH Needs Assessment Workgroup established criteria, weighting, and ranking parameters (see ranking worksheet attached to the State Priorities section of this application). These were used uniformly to assess the importance of each of the health priorities identified as affecting MCH populations. A total of thirty-three (33) health conditions were selected. Given the diversity in background of the workgroup members, it was important they all have a baseline understanding of the epidemiology, severity, causes and strategies for each of the 33 health conditions. Thus, informational fact sheets (attached to this section of the application) were created and distributed for workgroup review. Members were divided into 6 teams, each given 5-7 health conditions to focus on. Each individual did a ranking worksheet on all 33 health conditions, then, as a group, they developed one consensus ranking worksheet on the 5-7 assigned health conditions. This dual approach (individual and group review) allowed for all members to be engaged on each health condition while still focusing on those that most impacted/interested them. The ranking worksheets were then compiled and weighted (70% weight for individual scores and 30% weight for group scores).

Seven state health priorities emerged from the MCH Needs Assessment process. All are new health priorities. Previous state health priorities have been met or were duplicative of national performance measures. As of June 2009, Delaware's MCH priorities include:

1. Infant Mortality
Reduce infant mortality and eliminate the disparity in infant mortality for African American women.

2. Prematurity
Reduce births occurring between 32 and 36 weeks gestation.

3. Low birth weight/Very low birth weight
Reduce low birth weight (<=2500 grams) and very low birth weight (<=1500 grams) deliveries.

4. Child/Teen obesity and overweight
Decrease obesity and overweight among children and youth between the ages of 6-19.

5. Obesity among women of childbearing age
Decrease obesity among women of childbearing age, those between 15-44.

6. Unintentional injury mortality among children and youth
Decrease unintentional injuries among children and youth 0-21.

7. Teen smoking
Decrease tobacco use among adolescents.

After comments received at the HRSA MCH Block Grant meeting that was held on August 11, 2009, 2 additonal state priority areas were identified. These are:

8. To increase the effectiveness and efficiency of organizations that serve families of children with special health care needs throughout Delaware; and

9. Increasing the percentage of children with low/no risk of developmental, behavioral or social delays.

III. State Overview

A. Overview

Introduction

/2010/ The designated Title V Maternal and Child Health (MCH) agency in Delaware is the Department of Health and Social Services (DHSS), Division of Public Health (DPH) directed by Karyl Rattay, MD, MS, FAAP, FACPM. Dr. Rattay assumed the leadership of DPH in May 2009. //2010// Within DPH, the Family Health and Systems Management (FHSM) section is responsible for the planning, implementation, coordination and evaluation of maternal and child health programs. The section is headed by a Section Chief who is also the State MCH Director, Alisa Olshefsky, M.P.H. In addition to the Title V funded programs (which includes the Children with Special Health Care Needs [CSHCN] Program), the section is also responsible for a number of other MCH-related programs and activities including the Title X Family Planning Program, the Early Childhood Comprehensive Systems (ECCS) Program, the Newborn Metabolic Screening Program, the Newborn Hearing Screening Program, the Adolescent Health Program, the Infant Mortality Program, the Center for Family Health Research and Epidemiology, the Birth Defects Registry, the Autism Registry, and the Health Systems Management Bureau (including program management of rural health, Federally Qualified Health Centers [FQHCs], the Conrad State 30/J-1 Visa Program - a recruitment program for physicians - and the State Systems Development Initiative [SSDI]).

The Title V MCH Block Grant funds field staff positions in community public health clinics for four key programs. These programs are Smart Start, Kids Kare, Child Development Watch (CDW), and the State's Oral Health Program. These field staff are under the direction of the State's Medical Director, Herman Ellis, M.D. Smart Start is a prenatal program addressing women at-risk for poor birth outcomes. Kids Kare is a case management program focusing on child health for children and adolescents from birth through 21 years of age. CDW is a program dedicated to CSHCN from birth through 3 years of age. In addition to Title V funds, state general funds also support field staff in these programs.

Title V MCH Block Grant funds are also used to fund positions within DPH's FHSM Section. These positions include the Bureau Director for Reproductive and Adolescent Health, a Management Analyst and an Administrative Assistant.

Each of the programs within FHSM is integrated with a common mission and strategic objectives. The mission of the FHSM section is to improve the health of families and provide leadership to communities in the development of health systems. FHSM accomplishes its mission by:
• developing, coordinating and evaluating programs and initiatives to improve the health of women, infants, children, adolescents and those with special health care needs;
• monitoring health status through newborn screening (metabolic disorders and hearing), birth defects and autism registries;
• eliminating disparities in maternal and child health outcomes, including infant mortality;
• ensuring access to adolescent health care services through School-Based Health Centers (SBHCs) and implementing programs to reduce teen pregnancy;
• applying epidemiology and research to improve delivery of quality health care to women, children and families;
• enhancing reproductive health and ensuring access to family planning services;
• translating evidence into practice to improve early childhood comprehensive systems of care; and
• ensuring health systems across the state have the ability to meet Delawareans' health care needs by focusing on primary care, rural health, identifying and addressing health care provider shortages, and helping to improve access to data and health information.

In brief, FHSM's programs address the following areas. The Office of CSHCN works closely with

CDW, the birth to three program, and other organizations throughout the State to coordinate services and address key issues including transition to adult services, family involvement and capacity building. Smart Start is the state's prenatal program for at-risk women and is available statewide through DPH Clinics and the Visiting Nurses Association. Smart Start is a collaborative effort between DPH and the state's Medicaid agency, the Division of Medicaid and Medical Assistance (DMMA). Kids Kare, a child health program, provides case management to children with serious medical issues and is available statewide through DPH clinic sites. Title X, the federal Family Planning Program, works closely with Title V on a wide range of issues including teen pregnancy prevention, preconception care and women's health issues. The ECCS Program partners with organizations throughout the state to plan, to develop and to implement partnerships to support child development and ensure that all Delaware's children are healthy and are ready to learn at school entry. The Infant Mortality Elimination Program funds contractual programs for at-risk pregnant women and preconception programs for women. The Infant Mortality Elimination Program's initiatives also include a research component (including the Pregnancy Risk Assessment Monitoring Surveillance survey) carried out through the Center for Family Health Research and Epidemiology and the State's Fetal Infant Mortality Review (FIMR) Program (through the Administrative Office of the Courts). The Newborn Metabolic Screening Program and Newborn Hearing Screening Program screen newborns for metabolic conditions and hearing deficiencies, as well as maintain the state's Birth Defects and Autism registries. The State Systems Development Initiative works with Title V in building capacity for data analysis and the linking of MCH datasets. SSDI also is a key participant in the MCH needs assessment process and works closely with the Center for Family Health Research and Epidemiology on pilot studies.

Title V related activities throughout FSHM and DPH support the stated section mission across each of the four levels of the MCH pyramid (direct services, enabling services, population-based services and infrastructure building activities) as detailed further throughout this application ***/2010/ (See Attached MCH Pyramid of Services) //2010//***. The next section broadly describes the current system contexts, including some of the principal characteristics of the state's maternal and child health populations.

Population Characteristics

Delaware is a small mid-Atlantic state located on the eastern seaboard of the United States. Geographically, the state's area encompasses only 1,983 square miles ranking Delaware 49th in size among all states. Delaware is bordered by the states of New Jersey, Pennsylvania and Maryland, as well as the Delaware River, Delaware Bay and Atlantic Ocean. Wilmington, the state's largest urban center is within an hour's drive to Baltimore, MD and Philadelphia, PA and within two hours driving distance from New York City and Washington, D.C.

According to the latest population estimates, in 2008 the State of Delaware had about 863,800 residents, of which 75% were Caucasian and 22% were African-American. The Hispanic population in Delaware has been increasing over the past decade. The latest estimates that are available regarding Hispanics are from 2007. In 2007, it was estimated that 6.5% of Delawareans were Hispanic. This is an increase of about 250% over the 2002 Hispanic population (estimated to be about 2.4% in 2002). According to the U.S. Census, in 2007, there were about 55,200 Hispanics in Delaware.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with 533,550 residents or about 61% of the state's total population. New Castle County also has a large population of African-American residents (about 24%) and within the city of Wilmington, the state's largest concentration of African-American residents (about 55 percent of the city's population). New Castle County also has the largest proportion of Hispanics. Kent County and Sussex County, located in the southern two-thirds of the state, are more rural than New Castle County. In 2008, the estimated population of Kent County was about 153,000 residents (75% Caucasian and 23% African-American). For Sussex County, which includes very

rural areas as well as coastal resort towns, the 2008 population was about 187,000 (85% Caucasian). Since 2000, the State's population has increased by about 9.8 percent.

Statewide, it is estimated that there are about 171,000 women of childbearing age (15-44 years of age) and 252,000 infants, children and adolescents aged 0-21 years of age. Annually in the state, about 13,000 infants are born. ***/2010/ For the five year period 2002-2006, Delaware had an infant mortality rate of 8.8 per 1,000 live births with the highest rates among African-American infants (15.9 per 1,000). //2010//***Delaware's infant mortality rate remains one of the highest in the nation and infant mortality prevention is a main health priority in the state.

Economic Indicators

Delaware's top five employers are the State of Delaware, the Bank of America, the DuPont Corporation, Christiana Health Care Systems and Dover Air Force Base. Among Delaware's largest private employers are businesses in the insurance, pharmaceutical, telecommunications, health care and financial services sectors. Comparatively speaking, Delaware's unemployment rate is low at 3.8% (12th lowest in the nation) as of December 2007 when the Bureau of Labor Statistics reported a national rate of 5.0 percent.

Delaware's 2004 per capita income was $35,728 and ranged from $27,292 in Kent County to $40,354 in New Castle County (Bureau of Economic Analysis). In 2005, approximately 14.5% of Delaware's children under age 18 were at or below 100% of the federal poverty level (U.S. Census Bureau).

Despite low employment, poverty remains a pervasive issue in the state with 13.8% of children 18 and under living at or below 100% of the Federal Poverty Level (FPL) and 33.9% of children 18 and under living at or below 200% of FPL. As in the nation at large, access to health insurance also remains a significant issue for many Delawareans. According to the University of Delaware's Center for Applied Demography and Survey Research, 14.8% of Delaware residents aged 0 to 64 years did not have health insurance in 2007.

In Delaware, 26% of households are headed by females with children and of these families, 26% are living in poverty. The median income of a 1 parent household in Delaware in 2007 was $23,338 compared to a median income of $67,492 for two parent households. The largest geographic disparity in the state, in this regard, is within the City of Wilmington, where 52% of households are headed by females. Statewide, only 5% of children with two parent households are living in poverty.

Geographic Disparities

Although the state is relatively small, disparities exist between the state's three counties as well as between rural and urban areas of the state with regard to healthcare access and utilization.

Statewide, the percentage of women accessing prenatal care in the first trimester is higher than the national average. For the 5 year period 2000-2004, 85.4% of pregnant women received prenatal care in the first trimester compared to 77.6% nationally. Kent and Sussex Counties and the City of Wilmington, however, were all below the state five year average of 84.7% for period 2001 to 2005 for prenatal care in the first trimester (77.7%, 71.7% and 84.7%, respectively).

In terms of birth outcomes, Wilmington is the geographic area with the highest percentages of low birth weights (14.4% compared to 9.4% statewide) and very low birth weights (3.0% compared to 1.9% statewide). Kent County has a higher infant mortality rate than the state as a whole (10.0 infant deaths per 1,000 live births compared to 9.2 infant deaths per 1,000 statewide) as does the City of Wilmington (12.4 infant deaths per 1,000 live births).

Kent County, Sussex County and the City of Wilmington have the highest teen birth rates (47.6,

57.4, and 92.6 births per 1,000 females ages 15-19, respectively) compared to the state rate (44.3 births per 1,000), however only Sussex County and the City of Wilmington exceed the state percentages of births to single mothers (51% and 69.7%, respectively, compared to 41.8% statewide),

Sussex County has the highest rates of youth tobacco, alcohol and substance use. In 2006, 23% of Sussex County's 11th Grade students smoked cigarettes (compared to 17% statewide), 48% drank alcohol (compared to 41% statewide) and 26% smoked marijuana (compared to 22% statewide).

Kent County is the county with the highest risk of poverty ratio (2.5, comparing female headed households to male householder families). However, both Kent and Sussex Counties exceed the statewide percent of female headed household families living in poverty (30.2% and 31%, respectively, compared to 26.3% statewide).

The City of Wilmington, similar to many urban areas throughout the nation, has correspondingly high rates of social risks and poor health outcomes such as juvenile arrests, high school drop-outs, HIV/AIDS (with a high proportion attributable to needle sharing) and sexually transmitted infections.

Children with Special Health Care Needs

Based on rates from the 2005/2006 National Survey of Children with Special Health Care Needs (NSCHSN) of families of children to age 18, it is estimated that about 34,500 Delaware children (17.5%) younger than age 18 years may have a special health care need. The survey data suggest that CSHCN live in about one in four Delaware households.

Based on the 2005/2006 Survey data, around 7,000 (20.4%) of Delaware's CSHCN have health conditions that consistently and often greatly affect their daily activities with rates among Black children with special health needs (22.5%) higher than their White counterparts (17.9%) and rates among families with incomes less than 100% FPL (32%) and less than 200% FPL (30.5%) higher than other income groups (12%-18%).

The NSCSHN Survey data suggest that in 2005 about 4,900 (14.2%) of Delaware's CSHCN younger than age 18 years had one or more unmet needs for specific health care services. Rates were higher for Black (27.7%) and Hispanic children (33.2%), compared to Caucasian children (11.7%). Close to half of children living in families less than 100% FPL had unmet needs, 19.4% for those 100% to 200%, and 12.7% 200% to 400%. Those families with private insurance were half as likely to report unmet needs (9.8%), compared to those with public insurance (17.9%).

The Survey data also indicate that 29.7% of all Delaware CSHCN are without family-centered care. More than 50% of Hispanic (53.8%) and 47.5% Black CSHCN are without family centered care (compared to 27.1% for Caucasian). About half of CSHCN living in families below 200% did not have family-centered care, compared to fewer than 30% at higher income levels.

This data on unmet needs, lack of family-centered care, and lack of a medical home indicates the increased needs of Black and Hispanic families and low-income families.

A recent survey of 15 pediatric practices throughout Delaware based on the Center for Medical Home Improvement's Medical Home index found 26.6% of these practices without elements required for partnering with families for care plan development (e. g. accessible office hours). In addition, one third (33.3%) of practices reported limited time and understanding of resources available to support transition to adult care.

According to the 2005/2006 National Survey of Children with Special Health Care Needs, 67.6% of families with CSHCN do not receive the services necessary to make the appropriate transition

to adult health care, work and independence. In 2007, the University of Delaware's Center for Disabilities Studies completed a survey project focusing on CSHCN transition to adult services. The survey focused on three main research questions: 1) Do young adults who leave pediatric medical care at A.I. DuPont Hospital (Delaware's only children's hospital), have primary and specialized adult medical care to address they typical and specialized chronic health care needs? 2) To what types of adult health care services do young adults have access after they transition from A.I. duPont. 3) How satisfied are these young adults and their families with the care they receive in the community?

The survey found that while the majority of young adults report access to specialist care, many of these young adults did not have a specialist. One-half of respondents did not have a specialist despite the perceived access and among those without a specialists, 39% reported they do know the type of specialist they need. A large majority of the respondents was very satisfied with their adult primary care provider, but about half expressed encountering difficulty in the process of transitioning to adult services.

Racial Disparities between Whites and Blacks

The Office of Minority Health for the Division of Public Health released a report on Health Disparities in Delaware in March of 2001. The following findings are significant:
• There were three indicators where the rate for Blacks was 3 times higher or more than the rate for Whites: HIV infection/AIDS death rate (10.66), homicide rate (4.3), and asthma hospitalization (3.3).
• Five indicators showed a disparity ratio of greater than 2:1: teen birth rate (2.71), late or no prenatal care (2.55), percent of low birth weight births (2.08), infant mortality (2.75), and diabetes death rate (2.47).
• Four indicators had a disparity ratio of greater than 1:1: alcohol-induced death rate (1.64), stroke death rate (1.62), cancer death rate (1.45) and heart disease death rate (1.20).

Current Priorities and Initiatives

Current priorities and initiatives include those that were identified as part of the 2005 Title V Needs Assessment, and several additional ones that have emerged since. As the infant mortality rate remains high in Delaware, this issue remains one of the three health priorities of the current Governor (Reduce the Incidence of Cancer, Reduce Infant Mortality, and Reduce Health Disparities). The 2005 Needs Assessment contained three priorities related to infant mortality. These were:
• Improve access to care in Kent and Sussex Counties and for black women throughout the state;
• Reduce black infant mortality; and
• Reduce the barriers to delivery of care to pregnant women and women of child bearing years and reduce those risk factors resulting in infant mortality and congenital abnormalities in their infants.

Currently, the Delaware Healthy Mothers and Infants Consortium (DHMIC) is in its third year of implementing 20 recommendations of a Governor's Infant Mortality Task Force to decrease infant mortality and improve maternal preconception health. The accomplishments of DHMIC are noted throughout this application and in the 2007 Annual Report that has been attached electronically to this section. The recommendations, at varying stages of implementation as they are phased in over a three year period are:

• Conduct a comprehensive review of every fetal and infant death in Delaware.
• Create a monitoring system to increase understanding of the risks faced by pregnant mothers in Delaware.
• Establish the Delaware Healthy Mother and Infant Consortium (DHMIC) as successor to the current Perinatal Board.
• Create the Center for Excellence in Maternal and Child Health and Epidemiology within the

Division of Public Health.
• Improve access to care for populations disproportionately impacted by infant mortality.
• Provide access to preconception care for all women of childbearing age with history of poor birth outcomes.
• Require that insurers cover services included in standards of care for preconception, prenatal and interconception care.
• Implement a comprehensive (holistic) Family Practice Team Model to provide continuous comprehensive care and comprehensive case management services to pregnant women and their infants up to two years post partum. Services will include comprehensive case management, trained resource mothers, outreach workers, nurses, social workers and nutritionists.
• Implement Federal Standards for Culturally and Linguistically Appropriate Services (CLAS).
• Create a cultural competence curriculum for providers.
• Improve comprehensive reproductive health services for all uninsured and underinsured Delawareans up to 650% of poverty.
• Fund an in-depth analysis of programs in Delaware that mitigate infant mortality and create and implement an ongoing process for continuous quality improvement for services and programs developed to eliminate infant mortality.
• Create an epidemiological surveillance system to evaluate and investigate trends and factors underlying infant mortality and disparity.
• Create a linked database system to meet data analysis and program assessment goals and improve health care and services provided to the public.
• Conduct a statewide education campaign on infant mortality targeted at high-risk populations.
• Expand the birth defect registry surveillance and make it proactive by broadening monitoring, early intervention and prevention programs.
• Continue to improve the statewide neonatal transport program.
• Evaluate environmental risk factors for poor birth outcomes.
• Promote oral health care, particularly the prevention and treatment of periodontal disease, as a component of comprehensive perinatal programs.
• Provide an annual report to the governor on current and future factors impacting the availability of obstetrical practitioners.

Six of the priorities in the 2005 Needs Assessment were related to adolescent/teen health:
• Ensure nutrition services to children and adolescents.
• Improve the dental health of children and adolescents.
• Reduce teen births.
• Reduce preventable disease in teens and adolescents.
• Reduce preventable injuries to children and adolescents.
• Improve the mental health of children and adolescents.

Nutrition. Through the ECCS program, as well as other areas of MCH, DPH partners with Nemours Health and Prevention Services. In 2007, Nemours launched its 5-2-1 Almost None "formula for a healthy lifestyle". This program was adopted by the State Nutrition Action Program, which includes the Child and Adult Care Food Program, WIC and Food Stamps. These programs serve more than 75,000 persons in Delaware.
Other child nutrition related activities include:
• The Newborn Screening Program distributes specialized formula to infants with PKU through the Specialty Formula Fund in Delaware;
• School-Based Wellness Centers provide dietary/nutrition assistance to students, in 2007. There were over 4,000 visits to School-Based Wellness Centers for nutrition issues.
• Smart Start, Kids Kare and Child Development Watch each have nutritionists as part of their case management teams.
• MCH program continue to partner with the Delaware WIC program to provide nutrition services statewide.

Dental Health. The Oral Health program at DPH provides dental services to adolescents, children and children with special health care needs. In August 2007, the Bureau of Oral Health

and Dental Services received a four-year, $160,000 grant from the Health Resources and Services Administration (HRSA), the "Targeted State MCH Oral Health Service Systems (TOHSS) Grant." The grant will increase families' access to oral health care and prevent oral disease by improving the public oral health infrastructure. Project goals are for children to receive early and comprehensive oral health services; and for families to understand the importance of oral health and learn how to achieve optimal oral health status.

The Delaware Oral Health Coalition is a new group formed to help reduce the high level of dental disease among the state's children. The State Oral Health Collaborative Systems Grant funded the creation of this diverse group representing approximately 20 organizations. Through local and national partnerships, the Coalition is developing an infrastructure to increase awareness about the importance of good oral health and its relationship to good overall health. It will also provide education about good oral health practices, and improve access to dental health providers.

The Oral Health Program also continues to further enhance and assure the dental services provided to underserved children in DPH's Seal-A-Smile sealant program, the Bureau of Oral Health and Dental Services has contracted with a private vendor to establish a case management referral system. Through the system, children identified through the sealant program are directed to a network of oral health providers who will accept them into their practices.

Reduce Teen Births. The Adolescent Health program, within the DPH FHSM section offers preventive health services for adolescents through school-based wellness centers and teen pregnancy prevention programming. In 2007 there were over 3,000 visits to School-Based Health Centers for pregnancy related issues. Also, the Infant Mortality Elimination Program supports teen pregnancy programming through a contract a mini-grant with Children and Families First.

Preventable Disease. School-Based Health Centers, Child Development Watch, Immunizations, the Office of Lead Poisoning Prevention, Kids Kare, Newborn Metabolic Screening, Newborn Hearing and the Family Practice Team Model programs provide preventive health services for children and adolescents statewide.

Preventable injury. Injury is one of the principal public health problems in Delaware. Between 1992 and 2001 injuries were the leading cause of death in the 1 to 44 year age group and the fourth leading cause of death over all age groups. From 2001 to 2003, an average of two people died from injuries, seven were hospitalized, and 190 suffered injuries that were severe enough to require emergency services each day in our state. Costs associated with these hospitalizations have increased from $45 million dollars in 2001 to $82 million dollars in 2003.

Strides have been made in Delaware to begin to reduce the number of injuries and resulting disabilities and premature deaths. For example, vehicle seat belt use in Delaware has increased from 64% in 1999 to 82% in 2004. In addition to the primary seat belt law, Delaware has passed other safety laws, and an Injury Prevention Coalition has been established to facilitate statewide injury prevention efforts.

A Strategic Plan for Injury Prevention (2005-2010) has been developed by expert work teams from the Delaware Coalition for Injury Prevention with guidance from the Division of Public Health's Office of Emergency Medical Services. The plan provides a framework to address nine core injuries: falls, motor vehicle injuries, traumatic brain and spinal cord injuries, suicide and suicide attempts, poisoning, fire injuries, dog bites, firearm injuries, and drowning and submersion injuries. The work teams used the public health approach to define each problem, identify risks and causes, and develop interventions to increase the public's awareness about the preventability of these injuries. The plan also seeks to reduce environmental risks, impact public policy and

decision-making, and redirect the economic and social losses now caused by injury.

Mental health. Each of Delaware's MCH programs provides referral services for child and adolescent mental health issues. Additionally, School-Based Health Centers provide mental health counseling and referral. In 2007, there were over 36,000 visits to School-Based Health Centers for emotional and/or substance abuse issues.

The final priority from the 2005 MCH Needs Assessment was to ensure medical home and coordinated services to children with special health needs. The Office of Children and with Special Health Care Needs, as part of Delaware's Maternal and Child Health program in the Division of Public Health, has a long history of family/professional partnerships by working closely with families and family-led organizations. Since 1993, Delaware's Birth to Three system in coordination with the Office of CSHCN have developed practices of family-centered care that have become part of the culture for DPH in addressing the needs of families of young children with special needs. Emphasis has been on family-centered care coordination. The plan of care is family-driven and all aspects of the program seek to integrate cultural and linguistic competence principles and practices. Statewide training for all DPH staff has been held in areas such as active listening, community wrap around resource planning, and coaching families for early intervention. In addition, the Office of CSHCN actively supports the development of family-driven organizations such as the Delaware New Scripts, the Family Medicaid Panel, and the Delaware Family Network through stipend support of unpaid family time through a contract with the Coordinating Council for Children with Disabilities (CCCD).

Other areas of concern that continue to be addressed include immunizations, reducing tobacco use, preventing child lead poisoning, developing a comprehensive early childhood system to ensure every child is ready to learn at school entry, and eliminating health disparities for the broad MCH population.

The DPH Immunizations Program is responsible for preventing and controlling transmissible vaccine-preventable diseases. CDC recently recognized the Delaware Immunization Program as the fourth most improved state, with a 21.4 percent increase in its childhood immunizations rate from 2003 to 2006.

Reducing tobacco-related illnesses and death is the goal of the Tobacco Prevention and Control Program. The team employs cessation and health communication interventions, surveillance and evaluation. Through sustained education, prevention and cessation strategies like the Quitline, the Tobacco Prevention and Control Program has successfully reduced smoking rates within the state. In 2007, Delaware recorded an all-time low smoking prevalence rate of 18.9% among its adults.

Unborn and young children who ingest lead can suffer permanent learning, hearing and behavioral problems, stunted growth and brain damage. The Office of Lead Poisoning Prevention (OLPP), within DPH, prevents childhood lead poisoning and promotes health among children (unborn through age six) through education, safe environments, universal screening and early intervention. OLPP promotes blood lead testing of all children at 12 months, and repeat testing children at high risk until age six. In homes of children with blood-lead levels exceeding the "level of concern" established by the U.S. Centers for Disease Control and Prevention (CDC), OLPP provides case management, education and inspection for lead hazards. Through the distribution of prevention materials, OLPP increases public awareness. The Office strives to prevent exposures by controlling lead hazards stemming from paint, dust, soil and lead-based elements in toys or ceramic dishware glazes.

The ECCS program is the lead in developing comprehensive early childhood systems. The program's scope of responsibilities include: 1) access to medical homes and health care coverage; 2) social-emotional development of young children; 3) early care and education; 4) parenting education; 5) family support; 6) Facilitate the Assuring Better Child Health and

Development (ABCD) grant; and 7) providing early childhood technical assistance, trainings and resources.

The DPH Office of Minority Health is responsible for data collection and analysis relevant to minority health status and disparities. The Office ensures DPH programs are tailored to eliminate disparate morbidity and mortality rates of minority populations and works to strengthen community and government partnerships to solve key health concerns and prevent disease. The Office also works to promote workforce diversity and develop culturally competent Public Health systems. In 2008, the Office released a report, "DHSS/Delaware Division of Public Health Cultural Competence Assessment." The report's recommendations are currently under review for next steps.

How did the Title V administrator determine the importance, magnitude, value, and priority of competing factors upon the environment of health services delivery in the State?

The Maternal and Child Health Director and the Title V administrator, as well as other maternal and child health program staff work closely with a number of key constituents, committees and agencies to determine the priorities for allocation of resources that include funding, staff time, infrastructure development and partnering. Among these groups are the Delaware Healthy Mother and Infant Consortium, the Coordinating Council for Children with Disabilities, the Early Comprehensive Childhood Systems Advisory Council, the Early Hearing Detection and Intervention Advisory Committee, the Newborn Screening Advisory Committee, the Title X program, the Injury Prevention Coalition, the Emergency Services for Children program, the Teen Pregnancy Prevention Advisory Board, School Boards throughout the state, the Division of Medicaid and Medical Assistance, the Department of Education, the Department of Services for Children, Youth and Their Families, and the Division of Developmental Disabilities.

Title V administrators also work with staff in the Public Health clinics. In the past year a series of site visits were completed and currently the Title V program is conducting environmental scans in preparation for the 2010 MCH Needs Assessment.

In 2006, House Bill 202 was signed into law creating the Delaware Healthy Mothers and Infants Consortium. As a health policy priority of the Governor, the reduction of infant mortality and associated morbidities has been a main thrust of many maternal and child health related efforts in Delaware.

Some of the priorities identified in the 2005 Needs Assessment overlap with current infant mortality reduction efforts; however, other issues have emerged, these include childhood obesity, autism, asthma, developmental screening among 0-5 year olds and repeat teen pregnancies. Each of these issues will be studied during the 2010 needs assessment process. //2009//

An attachment is included in this section.

B. Agency Capacity

/2009/ Preventive & Primary Care Services for Pregnant Women, Mothers and Infants

Currently, preventive and primary care services for pregnant women, mothers and infants are supported through Title V Maternal and Child Health Block Grant and state general funds in statewide programs for pregnant women, women of reproductive age, infants, children and adolescents. These programs include Smart Start, Kids Kare, home visits for first time mothers, the Family Practice Team Model, support for Resource Mothers, Newborn Metabolic Screening, Newborn Hearing Screening, and the Preconception Health program.
Smart Start is a prenatal case management program for at-risk women throughout the state.

Pregnant women are referred to the program through primary care practices, hospitals, WIC, Family Planning, Public Health clinics, Medicaid and other partner agencies. Women are screened for risk factors in three domains: nutrition, social and medical. Once enrolled pregnant women are seen at least monthly throughout their pregnancy and depending on their risk factors, provided information and education on topics including domestic violence, reproductive health, labor and delivery, alcohol, substance and tobacco use, and post partum issues. In 2007, over 1,200 women were enrolled in Smart Start and over 4,600 visits were completed by staff including nurses, social workers and nutritionists.

Kids Kare provides support for families with children who are at risk for delayed development, providing education and support to families with children. Nurses, nutritionists and social workers provide support and education to parents. Parent education emphasizes the importance of routine and preventive medical care. It helps parents to know: when and where to seek medical attention; when and where to get children immunized ; how to identify signs and symptoms of illness; what to expect as a child grows and develops, how to prevent injuries; how to develop healthy eating practices and how to strengthen parenting and coping skills.

The Family Practice Team Model (FPTM) program, a clinic/health center based holistic prenatal care program provides social support to women before birth and to women and infants up to two years after birth. Currently, 7 sites offer the FPTM located throughout the state. The FPTM was developed based on an identified need for services among women who delivered infants that were premature and/or low birth weight. The targeted groups of women for this program include African Americans, Hispanics and women with a history of previous pregnancy complications or poor birth outcomes. For example, 18% of the women served in 2007 had a history of prematurity, low-birthweight or infant death and 27% were coping with a chronic disease such as diabetes, hypertension or heart disease. The program's services include nutritional counseling, mental health services, community outreach, social services through case management and increased postpartum care which may, in part, prevent future poor birth outcomes. According to 2007 data, only 3 infant deaths occurred out of 1,292 pregnancies served through FTPM. This occurrence was 67% lower than expected among the at-risk group of women served by the program. Additionally, only 10 percent of pregnancies resulted in a premature birth and only 5% resulted in a low-birthweight infant, both indicators below the expected proportions of these outcomes.

The Preconception Care program, a new initiative under the Infant Mortality Elimination Program, is designed to help women plan their reproductive life course. The program offers education and information related to healthy diets, exercise, stress, chronic disease, reducing and eliminating risky behaviors such as alcohol, substance and tobacco use and understanding how previous pregnancies may affect subsequent pregnancies. Initial data suggest a positive impact in terms of birth spacing with 87% of women waiting more than 18 months before becoming pregnant again.

As part of the research completed in the design and implementation of both the FTPM and Preconception Care programs, the State of Delaware created a Registry for Improved Birth Outcomes. The registry, compiled from all births in Delaware occurring over during the past two decades, has helped to identify key risk factors associated with poor birth outcome (prematurity, low-birth weight and infant mortality). These factors include smoking, maternal weight (either too low or too high), chronic disease and short intervals between pregnancies.

The Newborn Metabolic Screening Program offers initial and confirmatory (second) screening for 37 conditions for every infant born in Delaware. The Newborn Metabolic Screening program also offers follow-up case management of positive screens to ensure identified infants and their families are linked to appropriate treatment services. In 2007, 12,666 infants were screened. The program also distributes specialized baby formula to infants with metabolic conditions.

The Newborn Hearing Screening Program offers universal screening. Currently, the program

screens over 93% of infants born in the state. The program also manages a hearing aid loaner program for children until a source is identified to obtain their own hearing aid. Two new pieces of legislation were passed this year. The first law expands the age limit for those eligible for hearing aid loaners from three to eighteen years of age. The second law requires insurers to cover up to $1,000 per hearing device per ear every three years for children with hearing loss up to 18 years of age.

Services for CSHCN

In Delaware, Children with Special Healthcare Needs (CSHCN) are served by the Birth to Three program for infants and toddlers aged 0-3 and by Kids Kare for children to age 21. The mission of the Birth to Three Early Intervention System is to enhance the development of infants and toddlers with, or at risk for disabilities or developmental delays, and to enhance the capacity of their families to meet the needs of their young children. Child Development Watch (CDW) is the statewide early intervention program under the Birth to Three Early Intervention System. CDW is a collaborative effort with staff from the Division of Public Health, the Department of Services for Children, Youth and Their Families, the Department of Education and the Alfred I. DuPont Hospital for Children working together to provide early intervention to young children with special health care needs and their families. The average monthly number of children participating in CDW during 2007 was 1,559. During the year, over 4% of children aged 0-3 years, received early intervention or periodic assessment and tracking through CDW.

CDW is evaluated on an ongoing basis. One of the evaluative tools is the annual Family Survey which is conducted via telephone with a stratified random sample of families based on geographic region, ethnicity and length of time in the program. The 2007 survey found:
- 97% of families indicated that they had overall satisfaction with the services they received;
- 94% of families perceived the program as accessible and receptive;
- 93% of families perceived change in themselves and their family;
- 93% of families perceived change in their child;
- 93% of families reported a positive perception of family decision-making opportunities;
- 92% of families reported a positive family-program relationship with CDW staff; and,
- 92% of families reported a positive perception of their quality of life.

The Office of Children with Special Health Care Needs, as part of Delaware's Maternal and Child Health program in the Division of Public Health, has a long history of family/professional partnerships by working closely with families and family-led organizations. Since 1993, Delaware's Birth to Three system in coordination with the Office of CSHCN have developed practices of family-centered care that have become part of the culture for DPH in addressing the needs of families of young children with special needs.

Child Development Watch utilizes a community team model. The CDW team includes members from the Division of Family Services, the Division of Management Services, the Department of Education, the Division of Developmental Disabilities Services and contractual staff to ensure children and families are linked with the appropriate array of services. The model also includes specialized community services provided in early education centers and daycare settings, where CDW provides outreach to care providers for educational purposes and follow-up services for Children with Special Health Care Needs.

Current efforts to provide coordination to youth transitioning to adult services include Delaware's Transition Initiative that sponsored a survey of youths moving to adult services in the community. Based in part on the research that found youth have difficulty securing specialty care in the adult community, A. I. duPont Hospital for Children of the Nemours Foundation has created an Office of Transition and clinical team to meet the needs of youth transitioning to adult community services. The Office of Transition team includes a nurse, a part-time medical doctor, a social worker, and support staff. It will be operational in summer, 2008. In addition, the Office of CSHCN also supports expansion of Internet based tools for families and youth with special health care

needs. Through a contract with the University of Delaware's Center for Disability Studies, Delaware's website for transition information continues to be updated to include specific contact information for medical and social needs.

/2010/ In Kent and Sussex Counties, Child Development Watch also has a program known as Specialized Community Services (SCS). SCS focuses on home visits to educate families that face behavioral, mental health or family dynamic challenges. The SCS provides the community with Stay n' Play, an initiative designed to educate parents about how to deal with children with behavioral and mental health issues. Over the past two years the SCS program has worked with 25-35% of the Child Development Watch caseload. //2010//

State Statutes Signed into Law in the Past Year

/2010/

HB 135 Dental Residency Program. This legislation would permit the Board to grant a limited license to a Director or Chairperson of a hospital dental or oral and maxillofacial surgery department and its associated residency programs, who would be permitted to train and teach future practitioners in dentistry or oral and maxillofacial surgery. At the current time, Delaware has a nationally recognized residency program in these fields. This legislation will enable Delaware hospitals to attract nationally recognized and uniquely qualified dentists to chair or direct these residency training programs. The limited license will permit the licensee to practice dentistry or oral and maxillofacial surgery only in the hospital or an associated institution.

HB 199 Developmental Screening of Infant & Toddlers. This Act requires that private health insurers in Delaware cover the developmental screenings for infants and toddlers that are recommended by the American Academy of Pediatrics and the Delaware Early Childhood Council. Such screenings are already covered for children in the state's Medicaid program. The estimated cost to policyholders of covering these screenings is three cents per member per month.

HB 269 Distribution of Tobacco Products. This bill requires a person engaged in the sale or distribution of tobacco products to demand proof of age from a prospective purchaser or recipient of such products who is under the age of 27 years. A notice is to be posted conspicuously at each tobacco vending machine as well as at each point of purchase. Also, the bill makes it unlawful to maintain such products except in a tobacco vending machine in any display accessible to customers that is not under the control of a cashier or employee.

HP 139 AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO THE DELAWARE HEALTHY CHILDREN PROGRAM. This Bill is awaiting signature and extends Delaware's Childrens' Health Insurance Program (CHIP) to include reduced-cost health insurance coverage for children of families with personal incomes above 200% of the Federal Poverty Level. However, a cost-sharing program is to be implemented under CHIP whereby payments, as determined by DHSS, must be paid on behalf of the child for such care; notwithstanding the above, the cost-sharing provision of the bill is designed to have the new program impose no cost whatsoever on the State unless funds are specifically appropriated for it.

HB 211. This law increased the tax on cigarettes from $1.15 to $1.60 per 20-cigarette pack.

SB 65. Parents of children with severe disabilities experience difficulty in identifying practitioners willing and able to provide effective dental care. Children with autism or

mental deficiency are often uncooperative with treatment. Children with postural or mobility impairments may be unable to transfer from a wheelchair or sit in a standard dental treatment chair. Strict application of "in-network" insurance restrictions exacerbates the parents dilemma since there may be no nearby in-network dentist willing and able to treat their child. When parents with secondary child Medicaid insurance are unable to effectively access private dental insurance, the result is an increase in Medicaid claims.

This law applies to insurers which include dental services in their benefits package. It allows parents with such private dental insurance to secure dental care for a child with a severe disability irrespective of "in-network" restrictions. Finally, it promotes the availability of in-network practitioners willing and able to treat such children.

//2010//

Cultural Competence

In 2007, the Delaware Division of Public Health (DPH)/DHSS contracted with the Center for Health Equality (CHE) at Drexel University's School of Public Health to conduct a cultural competence assessment of the division. The primary project objective was to apply a health care cultural competence protocol that was adapted, with the assistance of DPH staff, to the priorities and characteristics of the division. The process called for interviewing administrative, management and program personnel identified by the DPH, obtaining and ordering cultural competence-related materials across programs, and scoring and scaling the division according to the assessment's five-point "Spectrum of Cultural Competence."

Findings of this initiative included the following:

Ethnic/cultural characteristics of staff and clients of DPH. The composition of employees of DPH is approximately as follows: 74% Caucasian, 18% African American, 4% Hispanic and 3% Asian. A descriptive analysis by pay grade and race/ethnicity indicated that there are relatively little difference in representation among Caucasians, African Americans and Hispanics (72%, 86%, 91%, respectively) in entry level positions, however, representation in the middle levels of the organization are reflective of less diversity with the exception of Asian employees, substantially represented in these positions (65%). Finally, in the upper levels of DPH, there is no difference by race/ethnicity.

Mission, management and program priorities. The organization has identified cultural competence as an organizational concern and has included it as part of periodic assessments of community/client needs, although those assessments tend to vary by program. Administration understands the importance of diversity and cultural competence in the context of public health mission and programs and this is reflected in the strategic plan.
DPH has made efforts to incorporate diversity into its administration/management. However, there is a general sense that formal strategies are more likely occurring at the service/program level.

Direct service staff stated that they were working to design culturally and linguistically appropriate interventions related to their programs, including consideration of related outcomes, and soliciting advice from clients. Some were working to reflect a long term commitment to cultural competence.

Diversity education and training. Interviewees generally acknowledged that DPH offers some training and education for providers and administrative staff, usually through orientation. Some programs acknowledged formal cultural competence training (including internet) or direct service education (for providers).

There has been some effort to formally identify related resources. For example, Task Force Recommendations for the Delaware Department of Health and Social Services (DHSS) workforce development include "Workforce Diversity and Cultural Competence Tool Kits for health care providers and consumers, which is accessible from their website. Included within these recommendations are talking points on the importance of funding projects to reduce disparities, and documenting how DHHS has already worked to start reducing disparities for cancer, maternal and child health, and diabetes.

Resources and Materials. A review of internal and external reports, brochures, protocols and other written resources was completed as part of the cultural competence analysis of the DPH. Overall DPH has addressed cultural competence-related issues through various methods such as trainings, internal communications, public and private reports, forms and educational brochures. Internal documents illustrate that DPH has planned inclusion of strategies to address working with diverse populations to insure they receive the array of services offered by the organization. For example, a strategic plan for special populations in public health related emergencies outlines how the needs of non-English speakers, people with disabilities, homeless people, pregnant women and children should all be integrated into preparedness programs. In addition, a list based on populations served by the Southern Health Services illustrates the state's great diversity in DPH serves clients from 45 different countries.

DPH Links to Community. The Division of Public Health has a number of important and established links to the community with a substantial number of these links formed with programs and personnel employed within the service arm of the organization. Through their work with clients, direct service staff have taken the lead to partner with community based organizations which include community advocacy groups, local service programs, numerous faith-based institutions (i.e., primarily churches), schools (i.e., colleges and universities) and community advisory groups. Many of the direct service personnel indicated that there were "too many community partners" to list. This speaks to the efforts on the part of DPH programs to be interactive, integrative and responsive to their communities. This was evident given the extensive list of organizations that DPH has worked with over the past two decades. Many of the staff that has worked with the community has indicated that "keeping a strong community connection is vital." The connections and work with the community organizations have included outreach support, mass media campaigns, educational opportunities and referral sources. The effectiveness of working with the community in these activities was rated very high.

Direct service staff have made substantial efforts to incorporate the community into programs that target a specific racial/ethnic group. Educational programs for breastfeeding and HIV were mentioned as models that linked to communities but also incorporated the needs of diverse clients (i.e., hiring bilingual staff). Direct service staff commented that the success of community partnerships is based on the recommendation of managers on the direct service side to encourage employees to participate in community meetings. A provider resource guide was also developed for clients that identified language spoken among health care providers in the community.

Addressing the language and communication needs of clients. Assessments from administration and direct service staff indicated that 25-50% of client base speaks Spanish. In addressing the needs of this group the direct service as well as administrative staff have had many successes. Management has been responsive to client language needs by hiring bilingual staff in the clinic. Client language needs are identified on enrollment applications, most materials for clients are available in Spanish (e.g., consent forms, client rights and responsibilities form, HIPAA forms and educational materials) and there are also Spanish messages on direct service phone lines. In addition, videos in clinic waiting rooms are in Spanish; and complaints about services can be taken in Spanish. Finally, service providers have access to the AT & T language line for interpreter services.

In addition to the relative strengths of DPH in striving for cultural competence, the report identified

areas for improvement. These areas include:
- Services tend to operate independently of each other and, as a result, there was little opportunity to engage across them or to learn from their experiences or initiatives.
- Insufficient resources to provide important cultural competence services, including restrictions and requirements regarding dollar allocations, limit scope and reach and make it difficult to prioritize cultural diversity given other pressing needs.
- From staff in administration and direct service there was very little to no information gathered related to a formal process for collecting and monitoring client based race and ethnic data. Direct service staff do not have a formal mechanism for capturing client language needs in electronic databases. Although individual programs have added this information to their intake questionnaires, these data are not captured for administration to observe trends in demographic shift of clients.
- Although, there were many connections to the community, most of the work to incorporate community was project specific and oriented toward direct service personnel.

To address these challenges, the DPH Office of Minority Health, along with other staff from DPH are in the process of developing action steps to further advance the cultural competence capacity of the Division. Among the recommendations that are under consideration are:

- Use the Workforce Development group to take a lead on diversity.
- Expand resources for recruiting a diverse workforce.
- Implement a cultural competence training program with a common content core but also with tailoring to specific service needs.
- Advancing language assistance programs and initiatives.
- Adapt, expand and centralize data and data system to more fully integrate diversity.
- Review office/environmental opportunities for addressing or featuring diversity.
- Establish a DPH resource for ongoing cultural competence activities.
- Provide a web-based source for discussing cultural competence, and diversity-related issues.
- Extending the community based resource into management and administration. //2009//

/2010/ In 2008, the Office of Minority Health released a Health Disparities Report Card that was designed to show the health disparity gaps among Delaware's racial and ethnic minorities, and to help monitor the community's and state's progress in eliminating those gaps.

Leading health and related indicators for broad racial and ethnic populations were included, along with supporting data and a letter grade to rank the health status of those groups.

This report card's aims are to:
• Inform the public and professionals, helping to guide them as they develop strategies, plans and programs to eliminate health disparities;
• Provide data to guide services and outreach provided by community-based organizations, faith-based organizations, state agencies and organizations, legislators, businesses, health care providers and hospitals; and
• Inform key decision makers on eliminating health disparities through policy reform and systems change.

Twenty-nine health and socioeconomic indicators were chosen for this report card to measure and describe the health status of Delaware's diverse population. These indicators were chosen based on their significance to health and health disparities and the availability of data (see attached Health Disparities Report Card).

//2010//
An attachment is included in this section.

C. Organizational Structure

/2010/ Governor Jack Markell heads the executive branch of Delaware's state government. Governor Markell is in his first year of a four year term. The Delaware Department of Health and Social Services (DHSS) is among the cabinet-level agencies in the executive branch. DHSS is led by Secretary Rita Langraff. Within DHSS, there are 12 divisions, the largest of which is the Division of Public Health (DPH). Karyl T. Rattay, MD is the Division Director for DPH.//2010//

In Delaware, there are no county/local health departments. DPH administers both state and local public health programs. DPH is structured into three main strands: Operations, Health Information and Science (HI&S), and Community Health Services. The Title V Maternal and Child Health (MCH) Block Grant program and the Children with Special Health Care Needs (CSHCN) program are part of the Family Health and Systems Management Section (FHSM), within the HI&S strand. HI&S is led by Paul Silverman, Dr.PH. Alisa Olshefsky, M.P.H. is the section chief for FHSM, as well as the state MCH Director. The MCH program includes components of four bureaus within FHSM, as well as linkages to other programs within DPH. Within FHSM, the Bureau of Maternal & Child Health is led by the MCH Deputy Director. This position is currently vacant due to a hiring freeze for state funded positions. The Bureau includes the Title V Block Grant, the Newborn Screening program, the Newborn Hearing program, the Genetics program, Early Childhood Comprehensive Systems and Children with Special Health Care Needs. The Bureau of Adolescent and Reproductive Health, under Gloria James, Ph.D. includes the Adolescent Health Program (which includes School-Based Wellness Centers and Teen Pregnancy Prevention) and the Title X Family Planning Program. The Bureau of Health Planning & Resources Management, led by Judith Chaconas includes the Offices of Primary Care & Rural Health and the State Systems Development Initiative. The Center for Family Health Research and Epidemiology, led by Mawuna Gardesey, M.B.A. includes the Infant Mortality Elimination Program. Research functions of this Center, including the Pregnancy Risk and Assessment Monitoring (PRAMS) survey, are led by a Centers for Disease Control and Prevention (CDC) MCH Epidemiologist, Charlan Kroelinger, Ph.D., who serves as the Science Director.

Nurses, social workers and nutritionists within the Smart Start, Kids Kare, and Child Development Watch Programs are directed by Herman Ellis, MD and Kristin Bennett, RN., MSN.

Beyond the FSHM section, several other critical programs are part of the MCH array of services and programs. These include Oral and Dental Health Services: led by Greg McClure, DMD; Northern Health Service Clinics, led by Anita Muir, M.S.; and Southern Health Clinics, led by Sherry Eshbach. Northern and Southern Health Services Clinic sites are the providers of three primary programs funded by Title V funds: Smart Start, Kids Kare and Child Development Watch.

DPH also includes a number of other programmatic areas which work closely with the MCH array of programs and activities. These programs are located throughout the strands of DPH and include Immunizations, Sexually Transmitted Diseases, Emergency Medical Services for Children and the WIC program.

//2010//The total Maternal and Child Health Partnership budget reported in this application includes Title V funds, state general funds and appropriated special funds. Staff are funded through each of the three sources of funds. This year's Title V funds includes $1,796,415 for 30.9 FTEs (3.0 FTES are projected to remain vacant during FY 2010). State general funds and appropriated special funds from Oral Health revenue will pay for 72.0 FTEs (a total of $5,122,543) and contractrual funds under the Infant Mortality Elimination program (a total of $4,800,000).

Attached are the organizational charts for the state government, DHSS, DPH, and Family Health and Systems Management Section. //2010//

An attachment is included in this section.

D. Other MCH Capacity

/2009/ Title V federal funds directly support 26.4 FTEs. A majority of these positions are clinic based positions (throughout the state) supporting Smart Start (a prenatal program for at-risk women); Kids KARE (a children's health services program); and Child Development Watch (a case management program for Children with Special Health Care Needs). The positions include: a Public Health Physician (.4 FTE); 3 Advanced Practice Nurses, 2 Nursing Supervisors, 2 Registered Nurses, 1 Licensed Practical Nurse, 3 Senior Medial Social Workers (2.5 FTEs), 3 Medical Records Technicians, a Senior Child Development Specialist, a Social Service Specialist, a Trainer/Educator, a Public Health Administrator, a Public Health Program Administrator, a Management Analyst, a Dental Assistant, a Health Program Coordinator (.5 FTE), Community Relations Officer (.5 FTE), a Health Program Coordinator (.5 FTE), and 5 Administrative Support Staff.
Of these positions, the Public Health Administrator (Bureau Chief for Adolescent and Reproductive Health), the Public Health Program Administrator (Director, Children with Special Health Care Needs), an Administrative Assistant and a Management Analyst are centrally located and serve in an administrative capacity supporting MCH programs throughout the state.

/2010/

In addition to the federally-funded positions, there are 72.0 FTEs that are state funded (65.0 FTEs) or funded through appropriated special funds (Oral Health Program Revenue). These positions include:

- ***5 Administrative Specialists***
- ***7.5 Advanced Practice Nurses***
- ***1 Section Chief (MCH Director)***
- ***1 Clinic Aide***
- ***4 Clinic Managers***
- ***8 Dental Assistants***
- ***6 Dentists***
- ***1 Genetics Coordinator***
- ***1 Medical Social Worker Consultant***
- ***5 Nursing Supervisors***
- ***1 Public Health Program Administrator***
- ***12.5 Registered Nurses***
- ***1 Senior Child Development Specialist***
- ***2.5 Senior Medical/Social Work Consultants***
- ***1 Social Worker***
- ***3 Social Service Specialists***
- ***8 Social Service Technicians***
- ***1 Teacher***
- ***1 Teacher's Aide***
- ***1 Trainer***

//2010//

The Division of Public Health employees a parent who serves in an advisory capacity to the CSHCN program and is also the AMCHP family delegate for the state of Delaware. This family member works with the Children with Special Needs Alert Program (SNAP) within the Emergency Medical Services for Children Program. SNAP is a program designed to notify emergency medical personnel of a child's special needs in advance.
DPH also has parents of Children with Special Health Care Needs that are among the staff within the Child Development Watch program. //2009//

/2010/

The Delaware SSDI program was able to accomplish several things this past year.

Access to Linked Health Statistics Data

The SSDI program manager has worked vigorously on building a relationship with the Health Statistics Center who houses the birth cohort file, birth certificates, infant death records and fetal death record. The Health Statistics Center now sends the SSDI program the birth cohort (merged birth certificates and infant death file) and the fetal death files once the data has been validated and the file cleaned.
Registry for Improved Birth Outcomes

The SSDI program coordinated efforts with the Center for Family Health Research and Epidemiology to create the Registry for Improved Birth Outcomes. The Registry is a list of all women who gave birth between 1989 and 2005(the most recent data the program has from Health Statistics), and who had a poor birth outcome. The Registry contains information on the risks that women with more than one poor birth outcome face in Delaware. Between 1989 and 2005, 22,531 women experienced at least one poor birth outcome in Delaware. Of the 22,531 women, 2,528 women experienced a second poor birth outcome (after removing multiples). The table below shows the percentage of first and second poor birth outcomes for the 2,528 women who experienced a second poor birth outcome.

Percentage of First and Second Poor Birth Outcomes, 1989-2005 (after removing multiples)

Poor Birth Outcome	First	Second
Infant Death 9%	6%	
Low Birth Weight	63%	57%
Premature Delivery	80%	84%

Of the 2528 women 4% or 96 had less than 9th grade level education, 66% or 1658 were high school educated and 30% or 758 were college educated. Forty four percent or 1112 were married and 56% or 1416 were unmarried. Of the 2528 women 31% or 781 had C-section deliveries and 6% or 161 had no prenatal visits. Ten percent of these women experienced pregnancy associated hypertension. (after removing multiples) The SSDI program is planning to expand the registry to include information on the women who did not experience a poor birth outcome for every pregnancy.

Active Birth Defects Surveillance System

The Family Health and Systems Management Section developed a working group on the Birth Defects and Autism Registries (BDR/AR). The group was staffed by Maternal & Child Health (MCH) Director, MCH Deputy Director, SSDI coordinator, Genetics Coordinator, contracted Newborn Screening Medical Director, Newborn Screening Coordinator and a Family Health Epidemiologist. These registries are required per regulation and are currently operating sub-optimally. The goals of the work group were to assess operation of the current BDR/AR, improve current reporting and increase frequency and completeness of data in the system. Maintaining a birth defects and autism surveillance system and registry is required by Title 16 of Delaware Code. Every diagnosis or treatment (or both) of a birth defect in any child under age 5 in DE is to be reported. Autism is to be reported for all children under 18. Currently, the birth defects registry and autism registry are not operating at their full potential. Reporting is incomplete and not systematic, there is limited reporting by private practitioners, there is little use of the standard reporting forms and there is incomplete data reported. The MCH Director worked

with the Newborn Screening Medical Director to create an active surveillance protocol and new abstraction form. The protocol was based on the National Birth Defects Prevention recommendations and recommendations from the Texas Birth Defects Surveillance program. The transition to active surveillance will occur in September 2009.

Healthy Women/Healthy Babies Module

The Family Health and Systems Management Section is working on adding Healthy Women/Healthy Babies (HWHB) program data as an additional module to the current Case Management System for the Newborn Metabolic, Hearing and Birth Defects Registry programs. The HWHB program is a combination of two programs, Preconception Care and the Family Practice Team Model which delivers prenatal care. The Preconception Care Program provides enhanced reproductive health care for women. The Family Practice Team Model Program provides enhanced prenatal care and interconception care for up to two years after the infant birth. Services are targeted to women who are African American, whose most recent pregnancy had a poor birth outcome (premature birth, stillbirth, low birth weight delivery or infant death), those with chronic diseases, late entry into prenatal care or less than high school education. HWHB program providers will be required to submit individual level data on all women served by the program. Data will be collected in the following areas:

- ***Demographics***
- ***Risk Factors***
- ***Preconception***
- ***Screenings, identified needs, services provided and referrals***
- ***Prenatal/Pregnancy history***
- ***Post-partum/Interconception***
- ***Infant outcomes***

Newborn Screening Program and Vital Statistics

Currently, the Newborn Screening program receives an Excel file weekly that contains certain identifying information on every baby born in Delaware from the Vital Statistics office. Once the file is received each baby is then manually entered into the search engine of the system to ensure every baby had a newborn metabolic and hearing screening. The SSDI and Newborn Screening programs are researching all options to make this process automated, including the option of a web based system. The Vital Statistics, Newborn Screening and SSDI programs have met and have all come to the consensus that this process needs to be more efficient. Once this project is complete efficiencies will gained for both the Vital Statistics and Newborn Screening programs as well ensuring every baby born in Delaware has a newborn metabolic and hearing screening. The programs are confident that the linkage will be complete within the next year. Funding for this project has been a barrier especially now as budget crunches have affected almost every program. The program is relying on the use of SSDI carryover funds.

Newborn Screening Program Data

The SSDI program supplied demographic data (sex, race, age of mother) on all identified metabolic disorders for the 2008 calendar year. The SSDI and Newborn Screening programs are also in the process of providing incidence rates of the metabolic conditions that Delaware screens for and posting them to the DPH website for public information. Currently, no Delaware Newborn Screening data is available to the public. The Delaware Newborn Hearing Screening data was not included in this project but will be done in the future.

The Delaware Newborn Screening program processed 24,721 specimens in 2008 with 12,699 being initial specimens. Ninety-one percent (91%) of the babies who received an initial screen also received a repeat screen. A total of 37 babies were identified with a disorder. Thirty-four babies were identified with a disorder by the initial screen and 3 babies were identified with a disorder by the repeat or second screen.

PRAMS

During the past year PRAMS completed its first full year (2008) of data collection. Preliminary results show that the required minimum response rate of 70% was achieved. Data for analysis will become available in January 2010. This is due to the lag time in sending a complete birth cohort file to Centers for Disease Control and the National Health Statistics Center. A partial year of data for 2007 was collected in 2007 and 2008. This data is available for internal review and analysis via PONDER, an online system provided by CDC that allows descriptive and crosstab analysis of PRAMS data. An experiment was carried out for a few sample groups comparing gift cards to two different stores - one a drug store, the other a convenience store that sells gasoline. At the conclusion of the experiment there was no noticeable difference in response rates between the two groups. Based on survey packets used in other states a new survey packet was designed for Delaware PRAMS. The packet now has a unified look with matching graphics for the envelope, introductory letter and the survey booklet. Year 03 objectives included continuation of data collection with a minimum 70% response rate, participation in a CDC/University of Illinois course on PRAMS survey analysis and completion of a PRAMS data analysis training course. Delaware PRAMS program results were presented at the national MCH conference in December 2008. Objectives for the next year (grant cycle, year 04) include implementation of Phase 6 of the survey, achieving a 70% response rate from eligible PRAMS participants, participation in the next CDC/UIC analysis course, analysis of 2007 PRAMS data and creation of information sheets of selected variables.
MCH 5-year Needs Assessment

The Delaware Title V program has begun the 5-year maternal and child health (MCH) needs assessment. The needs assessment is a crucial part of the MCH Title V Block Grant and will be used to identify priorities for program support and funding. The needs assessment workgroup is composed of Division of Public Health staff, social service program staff, parents/families, consumer advocates, representatives from key community organizations that serve key MCH populations. The workgroup identified 35 health problems that impact maternal and child health. The workgroup developed selection criteria which were used to prioritize the health problems. Division of Public Health staff from the Maternal and Child Health, the Center for Research and Epidemiology and the SSDI programs partnered to create information sheets for all 35 identified health problems. The information sheets covered current state and national data, trends, disparities as well as literature reviews. Each information sheet included all the following section titles:

- ***What it is***
- ***Facts***
- ***Causes***
- ***Impact and consequences***
- ***Prevention strategies***
- ***Community efforts***

These information sheets were used to rank the identified priority health issues (see below for a list of issues in ranked order).

Rank	Identified Health Condition
1	Childhood obesity
2	Infant mortality
3	Low birth weight infants
4	Preterm birth
5	Child and teen injuries and death
6	Child oral health
7	Obesity and overweight among women of childbearing age
8	Sexually transmitted diseases among teens
9	Child and teen injuries and deaths due to motor vehicle incidents
10	Youth violence
11	Homicide and suicide among teens

12 Maternal complications if pregnancy
13 Child asthma
14 Children with special health care needs coordination of medical care issues
15 Teen tobacco use
16 Teen pregnancy
17 Teen drug use
18 Teen alcohol use
19 Early childhood social and emotional development
20 Sudden infant death syndrome
21 Teen depression
22 Developmental delay
23 Maternal smoking during pregnancy
24 Preconception smoking
25 Child maltreatment and neglect
26 Inherited conditions
27 Vaccine preventable diseases
28 Maternal alcohol use during pregnancy
29 Inadequate birth spacing
30 Lead poisoning
31 Pregnant and postpartum depression
32 Transition issues for children with special healthcare needs
33 Intimate partner violence
34 Childhood cancer
35 Childhood sleep disorders

//2010//

E. State Agency Coordination

/2009/ As a small state, Delaware has many benefits, one of which is close collaboration between private and public agencies to address the maternal and child health needs of the state. Title V staff work with all agencies and constituency groups to assure that women, infants, children and adolescents, and children with special health care needs and their families have access to needed services.

At the highest organizational levels, the Delaware Health Care Commission provides an objective and informed forum for all stakeholders, including patients, insurers, employers, legislators, government agencies, health care providers and others. The Secretary of Delaware Health and Social Services, represents DPH and the MCH program on the Commission. The Commission serves as a policy-setting body and is designed to allow creative thinking across agency lines and across the public and private sectors. In recent years, the Commission has focused its efforts on health care access, cost and quality and oversees five major initiatives to meet its mission and goals. These initiative are:

- Uninsured Action Plan -- The Commission explores strategies to reserve and expand health insurance coverage through the State Planning Program and linking uninsured citizens with reliable health homes and affordable care through the Community Healthcare Access Program.
- Information & Technology - The Commission is working to develop a statewide clinical health exchange through the Delaware Health Information Network (DHIN).
- Health Professional Workforce Development -- The Commission assures an adequate supply of health care professional through the State Loan Repayment Program and the Health Workforce Data Committee and expanding educational opportunities for Delawareans through the Delaware Institute of Medical Education and Research (DIMER) and the Delaware Institute for Dental Education and Research (DIDER).

- Research and Policy Development -- The Committee performs ongoing research and provides accurate information for state policy makers.
- Specific Health Care Issues -- The Commission addresses specific health care conditions that are prevalent and warrant special attention and works in cooperation with other bodies within the State for this purpose.

Coordination of services and programs within the Title V MCH Block Grant program is accomplished through a number of committees and advisory boards with wide ranging representation. Programs partnered with Title V include the State's Early and Periodic, Screening, Diagnosis, and Treatment Program (EPDST), WIC, Part C IDEA, programs administered through the Department of Services for Children, Youth and Their Families, Division of Child Mental Health Services and Office of Early Prevention and Intervention, the Division of Visually Impaired, the Division of Developmental Disabilities Services, infant mortality initiatives (including the Family Practice Team Model and Preconception programs), and Family Planning programs.

Partners in the community include Nemours Health and Prevention Services, A.I. DuPont Hospital for Children, the Children's Hospital of Philadelphia, Johns Hopkins, and the State's hospitals (Christiana Care Health Systems, Bayhealth, Nanticoke, and Beebe). These and additional agencies (March of Dimes, Easter Seals for example) are typically represented on a number of Maternal and Child Health Committees including the Delaware Healthy Mothers and Infants Consortium.

Additional current advisory and coordinating committees include the Coordinating Council on Children with Disabilities (an advisory committee to the Children with Special Health Care Needs programs), the Teen Pregnancy Advisory Board (an advisory committee to the Director of Public Health), the Early Childhood Comprehensive Systems Advisory Council, the Newborn Screening Advisory Committee, the Newborn Hearing Advisory Committee, the State Systems Development Initiative Advisory Committee, the Birth Defects and Autism Registries Advisory Committee, the State Council for Persons with Disabilities (which includes the Traumatic Brain Injury Committee), the Developmental Disabilities Council, the Interagency Coordinating Council (an oversight committee for PART C), the Family Support Coordinating Committee, the Emergency Services for Children Advisory Board, the Trauma System Advisory Board, Healthy Delawareans with Disabilities 2010 (a committee that strategically plans preventing secondary health conditions among persons with disabilities, see attached Delaware Health Status for Children with Disabilities and Special Health Care Needs [April, 2008]), and the MCH Needs Assessment Working Group.

EPSDT, part of the State's Medicaid Program, is administered through the Division of Medicaid and Medical Assistance (DMMA), a sister division to DPH. Staff from DMMA and DPH routinely meet to discuss crosscutting issues related to outreach, enrollment and services utilization. DMMA is the lead agency for the State's Assuring Better Childhood Development (ABCD) initiative, in which a pilot program to implement standardized screening in pediatric practices is underway.

The Delaware WIC Program is located within DPH. Title V programs and WIC staff routinely work together at the state's public health clinic sites and referrals to WIC are made from each of the state's MCH programs.
The PART C IDEA program is administered through the Division of Management Services, also a sister agency of DPH. The Office of Children with Special Health Care Needs and Child Development Watch work closely with PART C to provide services to Children with Special Health Care Needs (birth to 3 years of age). Additionally, the Early Comprehensive Childhood Systems program works with PART C to ensure all Delaware Children are ready to start school.

The Department of Services for Children, Youth and Their Families is the primary agency in Delaware responsible for child mental health services (administered by the Division of Child

Mental Health Services). The ECCS program, Adolescent Health Program and CSHCN program each collaborate on initiatives related to MCH and child mental health. Additionally, each of these programs have advisory committees with representation from the Division of Child Mental Health Services. This year, the Division of Child Mental Health Services and the DPH Title V Maternal Child Health Program were co-applicants in a grant application to the Substance Abuse and Mental Health Services Administration to integrate physical and behavioral health preventive services for children 0 to 8 years of age.

The Division of the Visually Impaired and the Division of Developmental Disabilities Services are both partners with the Title V, Children with Special Health Care Need Program. Both of these Divisions are within the same cabinet-level department as the Division of Public Health.
The Delaware Healthy Mothers and Infants Consortium (DHMIC) is a Governor appointed body consisting of academics, neonatologists, a hospital director, nurses, department secretaries, consumers, the faith-based community and legislators. In addition to these appointed members the Consortium includes statewide representation from numerous stakeholders in each of its five committees (Data & Science, Education & Prevention, Health Disparities, Standards of Care and Systems of Care). The Consortium, now in its third year of work, is a key body for coordinating maternal and infant health issues in the state, especially issues related to infant mortality.

The Title X Family Planning Program within the same section as the Title V Maternal and Child Health program, works in close partnership with many MCH related initiatives including teen pregnancy prevention, women's health and infant mortality. Title X also supports staff located throughout the state in both contractual programs and Public Health Clinics. Referrals are routinely made between the Title V programs and Title X programs, as well as WIC.

The State Systems Development Initiative (SSDI) includes an advisory committee with representation from each of the key agencies with MCH related data. The Committee consists of the SSDI Coordinator, the Title V Program Administrator, the WIC Director, the Bureau Chief of Health Systems Management, the Newborn Screening Director, an Information Technology representative, representatives from School-Based Wellness Centers, staff from Northern Health Services and Southern Health Services (the regional offices for Public Health Clinics), representatives of the CSHCN, ECCS, Family Planning, Genetics programs, epidemiologists from the Center for Family Health Research and Epidemiology, and a representative from the Delaware Medicaid Program. The committee meets routinely to discuss ideas for linking data, identifying appropriate research questions for pilot studies and advising the SSDI coordinator on systems related issues.

The MCH Needs Assessment workgroup, initially formed in March 2008 includes representatives from each area of DPH's maternal and child health programs. In the coming year this group will be expanded, as needed, to include representation from other public/private agencies.

Federally Qualified Health Centers (FQHCs) and the state's rural health program are also closely related to the MCH program. Administrators overseeing these efforts are under the supervision of the state's MCH Director. Additionally, the Office of Oral Health and Dental Services, within DPH collaborates closely with the MCH program, including the Office of Children with Special Health Care Needs. //2009//

F. Health Systems Capacity Indicators

Introduction

In FY 2007, the Division of Public Health implemented a Center for Excellence in Maternal and Child Health Epidemiology. The primary responsibility of this unit is to conduct and collaborate on research initiatives related to Maternal and Child Health with an emphasis on Infant Mortality and Poor Birth Outcomes. The Center works closely with the State Vital Statistics Office and Medicaid to study and monitor measures related to maternal and child health and associated health systems capacity indicators. Center staff provides expertise on research, data and

statistics and share information internally with other Title V staff, as well as with numerous other partners in the Division, State and larger community.

/2010/ The Center's name has changed to the Center for Family Health Research and Epidemiology. During the past year the Center has contracted with APS Healthcare to provide research and consulting on epidemiological studies related to maternal and child health. In addition to the Center, the state's State Systems Development Initiative (SSDI) provides resources for ad hoc reports involving multiple databases (Vital Statistics, PRAMS, Newborn Screening, etc.). //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	69.1	69.1	69.1	69.1	69.1
Numerator	378	378	378	378	378
Denominator	54668	54668	54668	54668	54668
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data were not available at time of submission. We anticipate more recent data will be available over the next year.

Notes - 2007
At the time of submittting the 2009 MCH Block Grant application, the latest available hospital discharge data is 2004.

Narrative:
The 2004 final rate, 2005 provision rate and 2006 provision rate are one-year rates for children hospitalized for asthma. The rates in 2002 and 2003 are five year moving average rates.

In August 2005, the Division of Public Health and the Department of Natural Resources and Environmental Control released a report, "The Burden of Asthma in Delaware. The report provided an overall description of asthma in Delaware that included prevalence statistics, a profile of persons affected by asthma, health care utilization among persons with asthma and economic and social costs of asthma.

The Department of Education, as part of its School Improvement Imitative incorporates guidelines concerning school health. Asthma is one of the topics addressed. Among the strategies stated are: Obtaining written action plans for each student with asthma; supporting access to appropriate health care for students with asthma; integrating asthma and lung disease education into the classroom; participating in the YRBS and Delaware School surveys and offering Asthma Awareness Days to educate family and community members.

/2010/ In 2003, 11.7% of Delaware adults (about 72,000) reported having asthma at some time during their lives, according to the Delaware Behavioral Risk Factor Survey. About 7.5% (or 46,000 adults) currently have asthma.

Delaware's prevalence is the same as the national prevalence for 2003.

Asthma appears to be slightly more prevalent among young people. In the Delaware Youth Risk Behavior Survey for 2003, about 19% of high school students reported having been diagnosed with asthma; and 6.5% said they had an asthma attack in the past 12 months.

Delaware's asthma-related hospital discharge rate in general is comparable to the national rate.

Children under age 4 are more than twice as likely to be hospitalized with asthma than any other age group. They are about 4 times as likely to have an asthma-related hospitalization than adults. The report estimates about 3,000 asthma-related hospitalizations of young children a year.

In Delaware, African American residents are hospitalized because of asthma at rates nearly three times greater than whites. Neither the lifetime nor the current prevalence rates have such a high level of disparity.

There is no central registry of emergency room data, so the report examines data from two insurance plans--state employees and Medicaid. Medicaid members are almost three times as likely to use emergency room services for asthma treatment.

In 2000 and 2001, the most recent years for which data are available, there were 17 deaths per year from asthma in Delaware.

Economic Issues
Charges to Medicaid for asthma medications more than doubled, from $4.4 million in 2000 to $9.7 million in 2003. Total asthma-related Medicaid charges in 2003 were $13.9 million.

Total asthma-related claims from the state employee plan in 2003 were $2.6 million.

Total statewide charges for asthma treatment and medications could be as high as $25 to $30 million a year.

Asthma also affects productivity and quality of life. According to the Delaware Behavioral Risk Factor Survey, about 23% of adults with asthma were unable to work or carry out daily activities for one or more days during the past month.

Environmental Factors

Smoking and airborne pollution are major triggers for asthma symptoms.

Eight years of evidence-based, comprehensive tobacco prevention and education programs in the state have resulted in significant reductions in cigarette smoking in our state. Prevalence of regular smoking among high school students--those who smoke on at least 20 days of every month--decreased from 15% in 2000 to 9% in 2004, according to the Delaware Youth Tobacco Survey. The state's strong Clean Indoor Act is also protecting people with asthma from exposure to second-hand tobacco smoke in public places.

The Department of Natural Resources and Environmental Control (DNREC) monitors six air pollutants, and produces an Air Quality Index (AQI), which is available on the DNREC website. The report shows the number of days the AQI is rated unhealthy for sensitive individuals. New Castle County has the most days categorized as unhealthy. New Castle County has had more than 15 days classified as unhealthy in ten of the last 11 years. In contrast, Sussex County had less than 15 unhealthy AQI days in eight of 11 years, and Kent County has had more than 15 unhealthy AQI days only once (in 1998).

DNREC also monitors pollutants called Fine Particulate Matter, which are dangerous because they can penetrate more deeply into the lungs than large particles. Delaware has not been able to comply with the National Ambient Air Quality Standards for Fine Particulate Matter, because New Castle County's yearly average pollution level is greater than the standard.

For both ozone and Fine Particulate Matter, New Castle County has the highest air pollution levels, while Kent County has the lowest air pollution levels.

MCH is partnering with the Department of Natural Resources and Environmental Control (DNREC) to develop and implement as asthma intervention and community monitoring grogram. Once selected neighborhood in the City of Wilmington will implement community testing for PM25 and other pollutants. Once date is compiled and analyzed MCH will partner with community stakeholders to address the high rates of childhood asthma.

//2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	74.6	88.1	88.1	100.0	100.0
Numerator	4370	5421	5421	6666	6666
Denominator	5857	6154	6154	6666	6666
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data are not available at this time. Data are based on CMS Annual EPSDT Participation Report, 2007.

Notes - 2007
CMS Annual EPSDT Participation Report, 2007

Narrative:
In 2007, Delaware was successful in starting a Assuring Better Chili Health & Development (ABCD) initiative. This process will enable the State to access technical assistance to improve early screening systems.

/2010/ The Center for Research in Family Health and Epidemiology partnered with the Early Childhood Comprehensive Systems (ECCS) program to conduct an exploratory analysis of the PEDS (Parents Evaluation of Developmental Status) screening program in Delaware. The site identification and basic methodology were approved in a previous ABCD

(Assuring Better Child Health Development) application. Two sites, designated as Site A and Site B, volunteered to participate in population screening of infants. The Center staff recommended analysis of screens conducted among one age group of infants; nine months (range eight to eleven months) was selected based on high pediatric appointment attendance rates. All infants in this age range were sampled in the pilot in order to better understand who was screened at the practices as well as the demographics of infants unscreened.

A majority of infants eligible for screening were given the PEDS screening tool (77%). Although race and residence were significantly different between the two sites, these differences are attributed to location of the clinic (urban versus rural/suburban) and racial distribution of infants delivered within the state. Also, screenings were not significantly different by insurance status, infant age, and sex of infant, indicating universal screenings regardless of these characteristics. Finally, the primary reasons for a lack of PEDS screening were either the clinician determined the infant was within normal limits and therefore, did not conduct a screen, or documentation for lack of screening was not noted within the medical record.

In 2010, the ECCS program applied for a second round of assistance under the ABCD project. Also in the past year, legislation has been passed in Delaware and is currently awaiting the Governor's signature. This legislation would require reimbursement for developmental screening in early childhood. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	NaN				
Numerator	0	0	0	0	0
Denominator	0				
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2008
All infants are eligible for Medicaid and therefore do not get SCHIP

Notes - 2007
All infants are eligible for Medicaid and therefore do not get SCHIP

Notes - 2006
All infants are eligible for Medicaid and therefore do not get SCHIP

Narrative:
All infants are eligible for Medicaid and therefore are not enrolled into SCHIP until after 12 months of age.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	80.6	80.6	71.3	71.3	71.3
Numerator	9150	9150	8450	8450	8450
Denominator	11358	11358	11857	11857	11857
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available at this time.

Notes - 2006
2006 Vital Statistics

Narrative:
In State Fiscal Year 2007, Delaware implemented a Comprehensive (Holistic) Family Practice Team Model. This program is a direct services model targeting disparity in access to care, specifically among minority and lower income populations. The Family Practice Team model is a community-based model aimed at increasing access to supplemental care among targeted populations through combining prenatal and medical care with social services, nutrition services, and other components of health services coordinated by a case management system. The program is funded to cover areas of care not typically paid for by insurance providers and to provide care during time periods where insurance coverage is limited or for identified gaps in service.

/2010/ Wilmington, an area where maternal risks factors are the worst in the state, had a 16% increase in the number of women receiving first trimester prenatal care, from 71% in the 1990--94 to 82% in 2002--06. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	94.8	94.8	93.8	94.2	94.2
Numerator	78004	78004	81133	89704	89704
Denominator	82292	82292	86503	95253	95253
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The percent of potentially Medicaid-eligible children who have received a service paid by Delaware's Medicaid Program is reported in Table 7A.

The Kids Kare, Smart Start and Child Development program refer families to Medicaid.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	41.1	42.8	45.4	33.4	33.4
Numerator	6107	6743	7472	5684	5684
Denominator	14870	15756	16474	16996	16996
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
CMS Annual EPSDT Participation Report, 2007

Notes - 2006
CMS Annual EPSDT Participation Report, 2006.

Narrative:
In 2007, the Delaware Healthy Children Program (DCHP) began offering dental coverage for all of its members. The legislation authorizing these services will enable approximately 500 additional children to have the opportunity to obtain regular dental care by providing comprehensive benefits, competitive reimbursement fees, and streamlined claims processing. Under the benefit, modeled after those available under the State's Medicaid program, services include oral exams, x-rays, cleanings, fluoride applications, fillings, and restorative and specialty services. Orthodontic care is also available.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	100.0	100.0	100.0	100.0	100.0

Numerator	3756	3334	3334	2927	2942
Denominator	3756	3334	3334	2927	2942
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The percent of the State's SSI beneficiaries less than 16 years old receiving rehabilitative services from the State's Children with Special Health Care Needs Program is reported in Table 8. 2006 data are provisional at this time.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	10.7	8.3	9.3

Narrative:
During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	payment source from birth certificate	9.8	8.3	8.9

Narrative:
During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this

application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	61.9	83.3	73.9

Narrative:
During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	61.1	79.1	71.2

Notes - 2010
Need to explain discrepancy between HSCI 04 and this form (5d).

Narrative:
During FY 2007, Delaware implemented new programs for at-risk women during the preconception and prenatal periods. The preconception programs are designed to expand preconception care services for high risk women in Delaware. The prenatal programs are based on the Family Practice Team Model. Both of these initiatives are discussed elsewhere in this

application and in the attached 2006 Annual Report for the Delaware Healthy Mother and Infant Consortium.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	

Notes - 2010
Infants are Medicaid eligible.

Narrative:
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants are reported in Table 6A.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	 200

Narrative:
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for children are reported in Table 6B.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

Pregnant Women	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	

Notes - 2010
Pregnant women are Medicaid eligible.

Narrative:
The percent of poverty level for eligibility in the State's Medicaid program for pregnant women is reported in Table 6C. Pregnant women do not receive SCHIP.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:

Two notable accomplishments in FY 2007 have improved the State's MCH program's access to policy and program relevant information. First, the Center for Excellence in Maternal and Child Health Epidemiology was created and fully staffed. This Center, within the State's Maternal and Child Health Branch, is composed of three full time staff dedicated exclusively to collecting, generating, and analyzing data in MCH. The staff provides current updates of local, state and national data to the Division of Public Health, the Department of Health and Social Services, collaborative and partnering agencies and the Delaware Healthy Mother and Infant Consortium. The goals of the Center are to impact all programs that provide services in MCH, provide expertise in applications for federal and other supplemental funding opportunities, and facilitate evaluation of all MCH-related programs. In FY 2007, the Center will implement the statewide PRAMS survey. Additionally, the Center is collaborating on research initiatives with a number of partners including the University of Delaware, the State Medicaid Office, Christiana Care Health Systems and Johns Hopkins University. The second accomplishment has been an internal reorganization that has placed the state's State Systems Development Initiative within the same section as the Maternal and Child Health Branch. During FFY 2007, a new SSDI Program Director was hired and a SSDI committee has been formed and has met several times to prioritize data set linkages and research questions.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2010

Narrative:
According to the Campaign for Tobacco-Free Kids, Delaware ranks 2nd in the nation among all states in funding tobacco prevention programs. Delaware is currently only one of three states that funds tobacco prevention programs at or above the minimum amounts recommended by the Centers for Disease Control and Prevention.

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2009/ Delaware continues to monitor progress on each of the State's priorities, performance measures and program activities, however some data sources present significant barriers for timely assessment. Two years ago, Delaware transitioned to an Electronic Vital Statistics Record System (EVRS). Since this transition, staff in the Health Statistics Section of DPH have continued to provide Vital Statistics and Hospital Discharge data as soon as possible. For this year the latest Vital Statistics data that are available are for 2006. The Vital Statistics data that are reported throughout the application's forms for 2007, therefore, are provisional. The latest hospital discharge data that are available are for 2005. The Hospital Discharge data-based indicators for 2006 and 2007 are also provisional.

DPH also maintains a dated information system the Community Health Information System (CHISYS). CHISYS was originally designed for billing purposes about 15 years ago. Presently, the system continues to be used for billing and payment purposes. In the past two years, a working group has been formed to study issues related to CHISYS for the purposes of reporting client utilization of DPH services. This working group has identified a number of issues related to the consistency of data entry across programs throughout the State.

Two important additions have been made to the State's capacity to monitor performance through indicator data. First, the Center for Family Health Research and Epidemiology was funded in 2006 and made operational in 2007. This Center provides important analyses of trends in women's, infant and family health. Two main accomplishments of this Center in the past year have been the establishment of a Registry for Improved Birth Outcomes and the implementation of the Pregnancy Risk Assessment Monitoring System. The Registry for Improved Birth Outcomes has informed policy makers about risk factors of women with repeated poor pregnancy outcomes such as low-birth weight, preterm birth and fetal/infant death. The initial year of PRAMS data is expected to ready for analyses sometime in the Fall of 2009. In addition to the Center for Family Health Research and Epidemiology, the State System Development Initiative (SSDI) has made important gains in identifying pertinent questions to be addressed with respect to linking databases. This year the SSDI project provided an analysis of birth defects using Newborn Screening/Birth Certificate data. This analysis is being used by a Birth Defects Registry working group to make recommendations for enhancing Delaware's Birth Defects Registry. The objective is to move from a passive registry to an active registry in 2009. //2009//
An attachment is included in this section.

B. State Priorities

/2009/ As depicted in the attached schematic diagram, the Delaware Maternal and Child Health programs address priorities, national performance measures and state performance measures across each level of the MCH pyramid (direct health services, enabling services, population-based services and capacity/infrastructure activities. Though not inclusive of all the activities supporting these outcome measures, this section briefly addresses the linkages and activities that point to the capacity and resource capability within the State's MCH programs.

Direct health care services are provided by Public Health Clinics in support of National Performance Measure (NPM) 4, "he percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need." These services are made available through pediatric services in the clinics, as well as the Child Development Watch and Kids Kare programs. State Performance Measure (SPM) 5, "Percent of women delivering live-born infants reporting any cigarette smoking during pregnancy" and NPM 15, "Percentage of women who smoke in the last three months of pregnancy" are addressed through DPH's smoking cessation programs and health education and counseling in Smart Start and the Family Practice Team Model. Family Planning Services, Smart Start,

Preconception Healthcare Services and the Family Practice Team Model each teach women the importance of adequate birth spacing (SPM 7). Together these efforts address the stated priorities of medical homes and coordinated care for CSHCN, access to care, reducing preventable disease, reducing disparities in the Black:White infant mortality ratio and reducing barriers to care.

Enabling services are offered as part of the case management efforts within Smart Start, Kids Kare, Child Development Watch and the Family Practice Team Model. These services are wide-ranging wrap around services for women, infants and children, as detailed throughout this application. Enabling services within these programs support each of the state's priorities. Adolescent enabling services are provided through School-Based Health Centers which provide referral for mental health, substance abuse and physical health issues.

Population Based Services address a number of State and National Performance Measures. These services include Newborn Screening (NPM 1), Newborn Hearing (NPM 12), WIC's Breastfeeding promotion efforts (NPM 11), the Infant Mortality Elimination Program's Education Campaign to raise awareness of preconception health (numerous indicators), youth injury prevention through Delaware's Emergency Medical Services for Children and the Injury Prevention Coalition (NPM 10) and many other efforts. Together, these programs and activities provide support for all the state's priority needs as identified in the 2005 MCH Needs Assessment.

Capacity/Infrastructure activities are also wide-ranging. These include a number of ongoing surveys (such as PRAMS, the Primary Care Physician Survey, the Youth Risk Behavior Survey, the CSHCN Family Satisfaction Survey), DPH's efforts to involve families in program planning and evaluation, and support for assorted committees, task forces and work groups throughout the state, as detailed throughout this application. Capacity building also includes the work of the Early Comprehensive Childhood Systems program, the Conrad/J-1 Visa program and the State Systems Development Initiative. //2009//

/2010/ As part of the activities of the past year, our efforts in FY 09 focused on a thorough assessment of the MCH Block Grant and rebuilding the ties and partnerships with the CYSHCN community. MCH formally partnered with Family to Family (F2F) to build family leaders to help inform the direction of MCH services. The MCH program also invested significant time and resources working to reduce the prevalence of Traumatic Brain Injury (TBI) and improve coordinated services for families impacted by TBI. The DPH MCH program took the lead on creating a statewide TBI Action Plan that has been endorsed by over twenty organizations serving those with special needs.

The MCH Director was appointed to three statewide councils that address systemic issues affecting those with special needs. This includes the Governor's Council for Exceptional Citizens, Developmental Disabilities Council and the State Council for Persons with Disabilities. Participation on these councils raises the visibility of CYSHCN issues and allows MCH to achieve economies by partnering on existing programs that serve families.

New or reinvigorated partnerships have been established over the last year that have advanced MCH priorities. These include:
- Revising the scope of services provided by the nurse home visiting program -- Smart Start. The program will use evidence-based strategies to serve a more targeted group of medium and high risk mothers/families.
- Formally partnering with the tobacco prevention and control program to support youth tobacco prevention.
- Formally partnering with the physical activity, nutrition and obesity program to target interventions toward families with young children.
- Improving the structure and operations of the state's infant mortality elimination coalition known as the Delaware Healthy Mother and Infant Consortium (DHMIC). DHMIC initiatives

were expanded in FY08-09 to include:
- addressing cultural competency of service providers.
- expanding access to a statewide preconception program. The program saw a 231% increase in the number of women served.
- increasing the number of women receiving enhanced prenatal care: 20% of all Delaware pregnancies are impacted by this program.

Population based services were also strengthen over the last year. The most significant of which is the transition from passive to active surveillance of birth defects. Using guidance from the Texas Birth Defects Surveillance Program, the DPH MCH program developed an active surveillance protocol, abstraction form and revised coding for selected conditions. A vendor was selected in June 2008 and active surveillance will commence in July 2008.

Capacity to implement initiatives in the priority areas has shifted. There are two crucial vacancies that have programmatic impact: CYSHCN Director and MCH Deputy Director. Both positions have been vacant for over a year and will remain so given the state hiring freeze. The CDC MCH Epidemiology assignee, who functioned as the state's MCH epidemiologist, returned to the CDC as of May 2009. These staffing issues require that existing staff take on new duties and that the program be creative in meeting the priority needs.

As of June 2009, APS Healthcare was contracted to provide epidemiology, research and evaluation services for all MCH programs, including Infant Mortality Elimination, Early Childhood Comprehensive Services and State Systems Development Initiative. Using one contractor to serve the gamut of MCH programs ensures efficiencies, builds horizontal linkages through program data and allows for multiple programs to effectively apply data and evidence to activities. This also fills the gap left by the MCH epidemiologist.

The programmatic duties of the CYSHCN Director and MCH Deputy Director are being performed by the MCH Director and the Child Health Director. Support, via contractual arrangement, will be provided by Health Equity Associates, LLC. The president of Health Equity Associates has extensive experience in special needs services and worked in the CYSHCN program in Pennsylvania. She will be responsible for implementing two key projects over the next year. These include:

1) Working with Delaware's programs and organizations that serve CYSHCN to develop a "umbrella organization" that will serve as a fiduciary agent and single point of entry for family information and referrals. This includes:

A. Facilitate organizational and inter-organizational meetings to come to a consensus on the operations of an "umbrella organization" which should include development of common principles and guidelines that all agencies agree to as a condition of participation. Parent representatives are to be engaged in this process.

B. Formally establish the "umbrella organization" as evidenced by operating procedures, memoranda of understanding, and joint planning.

C. Assess individual organizational capacity across several domains including, not limited to, governance, sustainability, strategic planning, and evaluation.

D. Develop a strategic plan with goals, objectives and timelines for the "umbrella organization." The broad categories for planning should include, but are not limited to: Information and Referral, Training, Professional Development, and Advocacy

2) Collaborate with the DPH MCH program to assess and evaluate the early intervention program for children and families with special needs. This includes the Newborn Hearing

Program, Newborn Screening Program and Child Development Watch. The assessment will include development of a process map indicating the entry, referral and follow-up process. The evaluation will include a small number of family interviews/assessments to understand the benefits and barriers (if any) to early intervention services. Recommendations for improving the efficiency of early intervention services will also be provided. //2010//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	99.3
Numerator	11337	12293	22	35	12544
Denominator	11337	12293	22	35	12627
Data Source					Newborn Screening Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2006
2006 data are for postive screens that receive appropriate follow-up clinical management. Prior year data are for all newborns receiving screening services (Delaware Newborn Screening Program).

a. Last Year's Accomplishments
In 2008, the Division of Public Health's Newborn Metabolic Screening Program completed analyses of 25,031 total specimens (12,544 initial specimens and 12,487 repeat specimens). The program screens for 37 disorders including amino acidopthies, organic acidurias, fatty oxidation disorders, hemoglobinopathies and endocrinopathies.

Staff from the Newborn Metabolic Screening Program continued to provide follow-up services when inital screens were not completed at the birthing facility and for confirmatory (second) screens. When initial or confirmatory screens are not completed at a hospital or testing center, referrals are made to Public Health Nursing for a home visit.

The Newborn Metabolic Screening program continued to provide quiality assurance visits at birthing facilities and hospitals and to provide educational presentations to medical professionals throughout the State.

The program also is responsible for the administration of the Specialty Formula Fund in Delaware. This fund provides specialty formula to infants in need.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The DPH Newborn Screening Program includes initial and repeat screens for 37 metabolic conditions.			X	
2. Newborns are followed until repeat screens are completed and infants are referred for appropriate treatment.			X	
3. The Delaware Forumla Fund provides specialized formula for infants in need.	X			
4. The Newborn Screening Program provide quality assurance monitoring to hospitals and birthing centers to ensure consistency and timliness in the screening process.				X
5. The Newborn Screening data system supports the birth defects and autism registries. Delaware is working toward an integrated child health data system.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In addition to the on-gaoing administration of the Newborn Metaobolic Screening Program, current year activities have included planning and implementing a web-based module for the Newborn Screening Data System. This module will allow medical professionals to access newborn screening results over the internet on a 24-hour/7 day per week basis.

In 2009, Delaware increased its fees for Newborn Screening. The additional revenues from the increase (from $78 per infant to $98 per specimen) will be used to purchase a new Tandem Mass Sectrometry (MS/MS) machine.

Newborn screening staff also worked with the MCH Director to determine the feasibility of using the Newborn Screening Data System as a core system for the development of an integrated child heath data system. During the year, plans were finalized to use the system for an enhanced birth defects registry. We are also currently investigating the possibility of using the system for long term follow-up of cases with metabolic disorders and tracking late on-set hearing loss.

c. Plan for the Coming Year

A main focus of the Newborn Metabolic Screening in the coming year will be to develop an Emergency Preparedness plan to ensure continued operation of the program during a national emergency or natural disaster. The program is also working on further development of the data system and increasing the frequency of management and utilization reports.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	60	65	65	65
Annual Indicator	56.9	56.9	56.9	61.1	61.1
Numerator					
Denominator					
Data Source					National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	65	65

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
According to the 2007 Child Development Watch Program Family Survey:

• Over 97% of families who responded to the telephone interview indicated that they had overall satisfaction with the services they received;
• Over 94% of families perceived the program as accessible and receptive;
• Over 93% of families perceived change in themselves and their family;
• Over 93% of families perceived change in their child;
• Over 93% of families reported a positive perception of family decision-making opportunities;
• Over 92% of families reported a positive family-program relationship with CDW staff; and
• Over 92% of families reported a positive perception of their quality of life.

The DPH CYSHCN program has collaborated with the new Family to Family program operated by the University of Delaware via grant from HRSA. The F2F grant aims to increase parent leaders and peer supports for families with CYSHCN. With MCH support, the F2F grant has been successful in:
• Hiring a Parent Leader trainer.

• Developing a Parent Leader training curriculum. The trainings will include information on Title V, advocacy, building confidence, problem solving, conflict resolution, telling your personal story, communication and listening skills.
• Recruit parents to sit on councils, including the MCH Needs Assessment Workgroup.
• Establishment of a F2F Family Leadership Council. Six families are currently participating.
• Organizing a families meeting to review and vet the MCH Needs Assessment priorities and strategies that relate to CYSHNC. This meeting was held on April 3, 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Development Watch has a strong level of family involvement in standards development, system monitoring and assisting with Individualized Family Service Plans.		X		X
2. Family to Family Centers provide health information to families of Children with Special Health Care Needs.		X		
3. The Coordinating Council for Children with Disabilities provides coordination and communication for issues realted to Children with Special Health Care Needs.				X
4. The Division of Public Health's MCH Program is facilitating a planning and development process for improving coordination and collaboration between family-serving organizations throughout the state.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CYSHCN program within MCH identified the need for enhanced coordination within organizations that serve the special needs populations. Organizations serving CYSHCN run the gamut from large well funded organizations to volunteer-led entities of one or two parents. Most have a disease/condition specific orientation but often share concerns and resource needs. In order to maximize limited resources the CYSHCN took the lead in conducting key informant interviews, a small needs assessment and convening a stakeholder's group. The CYSHCN stakeholders group was held on 5/8/09. This purpose of this meeting was to review the key informant interview themes and strategize together on how best to move forward. DPH proposed the establishment of an "umbrella" organization that will serve as a fiduciary agent and single point of entry for family information and referrals.

Based on the interviews and the stakeholder's meeting several main themes emerged.
1. Fragmentation
- multiple funding streams
- lack of coordination among State agencies

2. Duplication of Effort at the Community Organization Level
- disconnect between agency mission and scope
- the need for an authentic connection between an agency and a family vs. passing off families to others

- organizations knowing what each other does
- appropriate referral patterns (could also be considered as a part of capacity)

3. Case Management/Care Coordination
- need to identify organizations that offer this
- parents as coordinators

An attachment is included in this section.

c. Plan for the Coming Year
Continue working with the CYSHCN stakeholder's group to establish an umbrella organization to better meet the needs of children and families with special needs.

Assess and evaluate the early intervention system for children and families with special needs. This includes the Newborn Hearing Program, Newborn Screening Program and Child Development Watch. The assessment will include development of a process map indicating the entry, referral and follow-up process. The evaluation will include a small number of family interviews/assessments to understand the benefits and barriers (if any) to early intervention services. Recommendations for improving the efficiency of early intervention services will be identified and implemented.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	55	55	60	60	50
Annual Indicator	52.8	52.8	52.8	48.1	48.1
Numerator					
Denominator					
Data Source					National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Child Development Watch includes each child's primary care physician as a memor of a multidisciplinary team.

Since 2001, Delaware's Medicaid Program has provided enhanced reimbursement for case management services fo children with special health care needs medical home providers. Smart Start, Kids Kare and Child Development Watch refer families to medical homes, Medicaid and SCHIP.

The Division of Public Health and the Division of Medicaid and Medical Assitance were successful in their efforts to initiate a systems project improvement - the Assuring Better Child Development (ABCD) project. This project, in cooperation with the Delaware Chapter of the American Academy of Pediatrics, launched a pilot initiative in two pediatric practices in Delaware. The pilot implemented policies and practices that advance the use of standardized screening tools as part of well child care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Development Watch includes the child's primary care physician as a member of a multidisciplinary team.		X		
2. Children in Kids KARE and Child Development Watch are connected to a medical home and primary care physician.		X		
3. The ABCD project supports poicies to expand the use of standardized screening tools as part of well child care.				X
4. The current Delaware Primary Care Physician Survey includes an item to establish baseline information on the understanding of the AAP's medical home criteria.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
HB 199 Developmental Screening of Infant & Toddlers passed at the close of state fiscal year 2009. This Act requires that private health insurers in Delaware cover the developmental screenings for infants and toddlers that are recommended by the American Academy of Pediatrics and the Delaware Early Childhood Council. Such screenings are already covered for children in the state's Medicaid program. The estimated cost to policyholders of covering these screenings is three cents per member per month.

A question has been added to the Delaware Primary Care Physician Survey based on the Center for Medical Home Improvement's Medical Home Questionnaire. This question, "How

familiar/knowledgeable are you about the concept of a medical home as defined by the American Academy of Pediatrics?" established a statewide baseline indicator of the need for training on issues related to medical care. The survey found that 22.7% of physicians and 12.5% of pediatricians in Delaware had no knowledge of the medical home concept. However, 64.8% of pediatricians reported using the concepts of a medical home sometimes or often in their practice.

An attachment is included in this section.

c. Plan for the Coming Year

The absence of a medical home for all children in Delaware remains a critical issue. Under the Ready Child section of the Delaware's state plan for early childhood, Early Success II, the need for all children to have access to a medical home where they received developmentally appropriate, coordinated care is essential to the optimal health of all children. To address the lack of a consistent medical home model in Delaware, the ECCS Program is providing opportunities among agencies, medical providers, community stakeholders and policy leaders for collaboration on advancing the concept of a medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	67	67	70	70	65
Annual Indicator	66.7	66.7	66.7	63.2	63.2
Numerator					
Denominator					
Data Source					National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	65	65

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The CSHCN program worked with Medicaid and families to address barriers to services due to Medicaid denials. Over a dozen families were served throguh this inter-agency workgroup.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHAP, Delaware's health care insurance safety net program, connects low income families and uninsured children to physicians and health care resources.		X		
2. The Delaware Health Care Commission continues to promote policies that preserve existing coverage and expand coverage.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The CYSHCN program is supporting the following legislation that affects insurance for CYSHCN:

SB 65: Requires private insurance payors to cover out of network dental care for children with special needs. In-network dentists or orthodontists may not serve children with special needs given the behavioral or physical impairments. Thus, families are required to pay out of pocket for dental professionals able and willing to serve children with special needs. SB65 will require insurance pay for the for the out-of-network services, thus alleviating the added burden on the families.

HB 22: Extends CHIP coverage to families with incomes up to 300% FPL. This increase (level is currently 200%) will allow families with higher income to qualify for the program.

c. Plan for the Coming Year
Through the establishment on an umbrella organization and in partnership with F2F, the CYSHCN programs intents to pilot a family liaison program within one pediatric practices serving children with special needs. The family liaison will be responsible for helping families receive coordinated care, including finding and enrolling them in programs and services. The most important of which is medical insurance.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	75	75	80	80	90
Annual Indicator	72	72	72	88.1	88.1
Numerator					
Denominator					
Data Source					National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	92	92	92

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Child Development Watch, Specialized Community Services, Stay and Plays Stay and Play Centers provide developmental activities for children birth through 3 years of age. Led by a Certified Parent Educator, parents and children are invited to play together, listen to a story, learn new songs, finger plays and network with other families. Stay & Play Centers are part of the Parent As Teachers Program. They are located statewide, and FREE to families with no registration required.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. The Office of Children with Special Health Care needs supports web-based information on resources for families with Children with Special Health Care Needs through contractual arrangements with Delaware's Family 2 Family program.				X
2.				
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
According to the 2007 Child Development Family Survey:

46.3% of families report knowing their rights;
54.9% of families report the ability to effectively communicate their children's needs; and
54.3% of families feel enabled to help their children develop and learn.

Delaware is seeking to support families of children with special health care needs through the development of an umbrella organization - an overarching structure - that will support smaller organizations and groups throughout the state that serve families with children with special needs. This support will include information/referral, capacity building, education and advocacy.

c. Plan for the Coming Year
As discussed in NPM#2 the CYSHCN program intents to conduct a system wide evaluation of early intervention services for children and families. One of the goals of the assessment is to ensure services are community-based and easy to use (e.g. limited/no barriers to care). Services identified as difficult to navigate by families will be improved.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	20	20	20	25	45
Annual Indicator	5.8	5.8	5.8	42.4	42.4
Numerator					
Denominator					
Data Source					National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	45	45	50	50

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The Al DuPont, Delaware's only hospital for children, created an Office of Transition that became operational in summer 2008. The Office is staffed by a clinician, nurse, social worker and support staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A.I. DuPont Hospital has established an Office of Transition to meet the needs of youth transitioning to adult health care services.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Issues surrounding transition resonated with families interviewed for the CYSHCN component of the MCH Needs Assessment. Based on feedback from families and expert advice from the Office of Transition, DPH will be working on a transition plan for youth and young adults.

c. Plan for the Coming Year
Develop a state wide transition plan in partnership with the Office of Transition and the University of Delaware Center for Disabilities Studies.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	90	90	90	90	80
Annual Indicator	83.5	82.6	76	78.9	80.3
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	82	83	83	84

Notes - 2008
National Immunization Survey, Selected Vaccination Series by 19-35 Months of Age, Delaware 4:3:1:3:3:1. Estimated Vaccination Coverage, 2007. Confidence interval for the estimate is +/- 5.7.

Notes - 2007
National Immunization Survey, Selected Vaccination Series by 24 Months of Age, Delaware 4:3:1:3:3. Estimated Vaccination Coverage (March 2006-February 2007). Confidence interval for the estimate is +/- 6.1%.

Notes - 2006
2006 National Immunization Survey, Selected Vaccination Series by 24 Months of Age, Delaware 4:3:1:3:3. Data released February 2008 (Corrected).

a. Last Year's Accomplishments
The Immunization Coalition of Delaware continued its work in promoting seasonal influenza vaccination, promotion of HPV vaccination for girls and young and promoting best practices for adolescent well visits as opportunities for booster vaccinations.

The Governor and Lt. Governor made a proclamation during Infant Immunization Week (April 2009), highlighting the importance of keeping children up to date with immunizations and the continuing risk for many diseases that people take for granted but that are actually "still out there". This is in alignment with the DPH Immunization Program's bus poster campaign promoting childhood immunizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Nothern and Southern Health services (Public Health Clinic sites) provide immunizations at well child visits. These service are primarily targeted to under- and uninsured.	X			

2. The Division of Public Health participates in the Immunization Coalition of Delaware. This group identifies the need and addresses system-wide issues regarding immunizations.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Delaware ranks ninth highest in the nation for immunization of children ages 19-35 months, according to the National Immunization Survey by the Centers for Disease Control and Prevention.

The DPH Immunization Program is working with VFC providers to enhance reporting of vaccinations in the immunization registry, VacAttack. The program is exploring the opportunity of making VacAttack web-based to allow all providers who deliver vaccines to see patient immunization histories. This access can help reduce missed opportunities and increase the percent of infants and children who are fully up to date.

c. Plan for the Coming Year
Continue working with partners to implement the Immunize Every Size message. The goal of which is to:
- All children have access to vaccines;
- Healthcare providers are aware of immunization standards of practice;
- The latest recommendations on vaccines are available to providers; and
- Providers and the public have access to up-to-date answers to vaccine questions.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	29	28	27	26	20
Annual Indicator	24.6	22.2	22.0	22.0	22.0
Numerator	412	381	386	386	386
Denominator	16740	17170	17572	17572	17572
Data Source					Delaware Vital Statistics, 2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	20	20	20

Notes - 2007
2007 data are not available at this time.

a. Last Year's Accomplishments
Delaware's most recent data (2002-2006) showed a slight decrease in teen birth rates, which is different the national increase in the teen pregnancy rate for 2002.
From 1991-1995 to 2002-2006, Delaware teen (15-19) birth rates decreased 22.8% to 43.6 live births per 1,000 teens 15-19.

- White Delaware teen birth rates decreased 13% to 34.7 and black teen birth rates decreased 42% to 69.2. The larger decrease in black teen rates reduced the black/white disparity ratio from 3 in 1991-1995 to 2 in 2002-2006.
- The rural part of the state (Sussex County) continues to have the highest birth rates for teens.

The School Based Wellness Centers (SBWC) continued providing reproductive health services to teens across the state. In 2008, SBWC enrolled 83.8% of the school population (32,825). Of the total 56,461 visits, 1,036 of them were pregnancy related. In addition, there were 1,277 pregnancy tests administered resulting in 141 positive pregnancies. It is unknown how many of the 141 pregnancies resulted in a live birth.

The Alliance for Adolescent Pregnancy Prevention continues providing evidence-based interventions to teens using three proven programs: Wise Guys, Making a Difference and Making Proud Choices. In FY 08, AAPP reached 235 teens.

Title X is the federally supported and state supplemented family planning program. In 2008, there were 26,905 unduplicated clients who made 51,357 visits. Eighteen percent (18%) of the clients served were between 12-19 years of age.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Division of Public Health provides Teen Hope programming at six high schools with high risk populations. This program offers teen pregnancy prevention education and case management services to at risk teens.		X		
2. The Division of Public Health provides Wise Guys programming at high schools throughout the state. Wise Guys is a male responsibility, teen pregnancy prevention program.		X		
3. Title X, Family Planning provides reproductive health and pregnancy prevention services to teens at sites throughout the state.	X	X		
4. The Infant Mortality Elimination Program provides funding in the form of mini-grants for teen pregnancy prevention. The program also provide preconception health services.	X	X		
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
DPH is reassessing the reach of the Alliance for Adolescent Pregnancy Prevention (AAPP) programs. Given the limited amount of state funds for teen pregnancy prevention ($333.0 annually) it is important the funds be utilized in a manner that reaches those teen most at risk.

In November 2008, a School-Based Wellness Center (SBWC) Summit was convened to discuss the future of the centers and the state of teen health in Delaware. Based on stakeholder feedback, DPH heard the need to re-look at the delivery of reproductive health services within SBWC. Although STD testing is provided in 75% of all centers, none provide contraception for routine pregnancy prevention. Although this issue is controversial, it merits a discussion with each school district to share the community specific epidemiologic data that supports delivery of full reproductive health services at each SBWC.

c. Plan for the Coming Year
Carry-out school district specific meetings with advisory boards and Parent Teacher Organizations to share community-level data about teen pregnancy, STDs and infant mortality. DPH will also include evidence that supports reproductive health services in SBWC as a means to reduce adolescent risk taking behavior by delaying initiation of sexual intercourse, reducing the frequency of partners, increasing condom use and other forms of contraception.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	35	35	35	40	35
Annual Indicator	21.4	34	34	34	34
Numerator	286				
Denominator	1338				
Data Source					Delaware Dental Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	37	37	40	40

Notes - 2008
The 2007 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

Notes - 2007
The 2007 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

Notes - 2006
The 2006 indicator is based on a 2002 statewide survey of third grade children. Prior year indicators were obtained from CHCIS & Medicaid and only represent a select subset of the population. The statewide survey is scheduled to be repeated in 2007. The 2010 annual performance objective has been revised to reflect the HP2010 objective of 50%.

In the 2006-2007 School Year, the DPH Dental Program reported placing 1400 sealants.

a. Last Year's Accomplishments
Children active in Kids Kare, Child Health and WIC are referred to the Dental Clinic and/or private dental providers that accept Medicaid payments. Services include preventive and emergency services.

Tooth care and nutrition are discussed at each physical exam performed. Clients are referred to state-sponsored medical programs as possible sources of free or low-cost dental care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Divison of Public Health's Dental Program provides dental screening for the Special Oympics Program.	X			
2. Publ Health Dental Clinics offer comprehensive dental treatment for those in need.	X			
3. The Dental Loan Repayment Program continues. This program is an attempt to attract dentists to undersevered areas of the state.				X
4. The Dental Program's Seal a Smile initiative provides sealants and dental screening at elementary schools throughout the state.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Delaware Oral health Coalition is focused on reducing the high level of dental disease among the state's children. Through local and national partnerships, the Coalition is developing an infrastructure to increase awareness about the importance of good oral health and its relationship to good overall health.

c. Plan for the Coming Year
The Oral Health program will resume its Seal-A-Smile program to provide dental screenings, sealants, and oral hygiene instructions for second grade children in targeted high- risk schools. Professional seminars will be scheduled to provide training for general dentists to treat young children and children with special health care needs. Seminars and training will also be offered to physicians and nurses to enable them to provide dental evaluation and disease prevention methods.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.2	2.5	2.5	2.5	1.7
Annual Indicator	2.2	1.8	1.8	1.8	1.8
Numerator	11	9	9	9	9
Denominator	499038	500732	500732	500732	500732
Data Source					Hospital Discharge Data, 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7

Notes - 2008
This indicator is provided through Hospital Discharge data. Data for 2008 Hospital Discharges is not available at this time.

Notes - 2007
This indicator is provided through Hospital Discharge data. Data for 2006 and 2007 Hospital Discharges is not available at this time.

Notes - 2006
2006 data are not availabe. The reported rate for 2006 is provisional and based on the 2005 three year average rate.

a. Last Year's Accomplishments
The Office of Emergency Medical Services (OEMS) released its 2008 Childhood Injury in Delaware report in September. There were three notable findings since DPH published its report on injuries in 2001. First, the overall statewide injury death rate for children ages 0-19 dropped from 26.4 to 21.15 per 100,000. Secondly, hospital charges for childhood injury hospitalization for a four-year period skyrocketed from $19 million to $31.8 million. Lastly, the motor vehicle hospitalization rate for 15- to 19-year-olds dropped from 232 to 181 per 100,000.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Emergency Medical Services for Children and the Injury Prevention Coalition continue to address motor vehicle related injuries and deaths among children as a priority area in thier programming efforts.				X
2. Smart Start, Kids Kare and Child Development Watch		X		

complete safety assessments at clinic and home visits.				
3. State Service Center locations offer child safety seat loaners to parents who cannot affort to purchase one.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2008 the Office of Highway Safety worked on the following initiatives related to occupant safety in motor vehicles:

- Click It or Ticket Enforcement and Education Campaign
- Nighttime Seat Belt Enforcement Campaign
- Statewide Seat Belt Use Survey
- 'Tween Seat Belt Use Initiative
- Booster Seat Law Enforcement Research Project
- Child Passenger Safety Awareness Week (CPSAW)
- Child Passenger Safety Fitting Stations
- SAFETEA-LU Occupant Protection Incentive Grant Administration -- Sections 405 and 2011

c. Plan for the Coming Year
DPH MCH Program in partnership with the DPH Emergency Medical Services for Children Program, Safe Kids, Child Death Review and Injury Prevention Coalition will work on an injury prevention needs and resources assessment. DPH MCH will reach out the Children's Safety Network for technical assistance in conducting the needs assessment. Based on the findings and a thorough epidemiologic analysis, goals and objectives will be identified to address unintended injuries in the child and adolescent population. Prevention of deaths due to motor vehicle accidents will be a critical goal given that they were the leading cause of injury deaths (1996-2002) for those 0-19 years of age.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	36	36
Annual Indicator		10.6	35.7	30.6	30.6
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32	32	34	34	36

Notes - 2008
2005 National Immunization Survey, CDC.

Notes - 2007
2005 National Immunization Survey, CDC.

Notes - 2006
2006 data are not available. 2006 reported percentage is provisional and based on the 2004 National Immunization Survey, Geographic-specific Breastfeeding Rates for Children 6 months of age born in 2004.

a. Last Year's Accomplishments
WIC offers breastfeeding rooms where any breastfeeding mom can pump or breastfeed in privacy.

WIC provided support to lactation consultants and peers counselors. Lactation consultants are experts in the field of breastfeeding. They are licensed, trained professionals who are available to provide support and assistance to pregnant and nursing mothers. Peer counseors are women who have breastfed at least one infnat for a minimum of four months. Peer counselors receive intensive training in breastfeeding support WIC clients can reach a peer counselor by phone or through WIC clinics.

The Milford Health Unit includes a Registered Nurse who is a Certified Lactation Consultant. Additionally, Title V provides funding for staff to attend Lactation Consultant training on a periodic basis.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V si supporting a pilot program, "Best Smart," an enhancement to the Smart Start program. The goal of the program is to have at least 80% of program participants breastfeeding their infants at 6 months of age.		X		X
2. In June, 2009, the Delaware MCH program sponsored a statewide conference for medical professionals "Breast is Best." Over 150 professionals attended this full day educational opportunity.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
In 2009, the Office of Rural Health and the MCH Program provided funding for a pilot project, "Breast is Best," designed as an enhancement to Smart Start and in addition to available WIC breastfeeding services. The project paid for lactation consultant training, purchased breastfeeding supplies and educational materials and supported a statewide conference for professionals. The Breast is Best Conference was held on June 11th at PolyTech Adult Education Conference Center in Woodside. Speakers included breastfeeding educator Vergie Hughes, RN, MS, IBCLC, FILCA; breastfeeding advocate Dr. Joseph DiSanto from Brandywine Pediatrics; and Division Director, Dr. Karyl Rattay. The event was attended by 118 health care professionals (including private medical providers, state employees and community partners). The conference evaluation data from the attendees were very positive and indicate success in meeting conference objectives.

c. Plan for the Coming Year
Pending review of the Breast is Best pilot program data, we will look to expand this effort statewide.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99	100	100	100	100
Annual Indicator	98.1	98.2	98.4	93.7	98.7
Numerator	11889	12098	12147	11864	12468
Denominator	12121	12324	12342	12666	12627
Data Source					Delaware Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
The Newborn Hearing Screening program is currently reviewing 2007 information to ensure all records have been entered accurately into the data system. The data reported for 2007, therefore, is provisional at this time.

Notes - 2006
2006 Delaware Newborn Hearing program data.

a. Last Year's Accomplishments
In 2008, Delaware revised its guidelines for newborn hearing screening. The new guidelines call for tandem screening (OAE and ABR). The new guidelines will increase the accuracy of infants who are detected with hearing loss shortly after birth.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Delaware Early Hearing Detection and Intervention program supported a Delaware Chapter of Hands and Voices.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Newborn Hearing Screening Program has worked diligently on implementing the new guidelines. Included in this implementation was a revamping of the reporting forms as well as the data system that house the screening data. Also, the Newborn Screening Program supported the purchase of a dual screener for the Birthing Center of Delaware.

The Newborn Hearing Screening program worked closely with the Delaware Chapter of Hands and Voices as the organization applied for its 501 c 3 tax exemption.

The Delaware Infant Hearing Assessment and Intervention Program Advisory Board has shifted its focus from merely increasing screening utilization to a more in depth planning and develop to ensure entry into early intervention services.

c. Plan for the Coming Year
In the coming year, Delaware plans to expand its efforts with the Delaware Chapter of Hands and Voices by implementing the Guide by Your Side Program. This program will provide peer-to-peer education and information to families who are faced with making early intervention services decisions for their children who are diagnosed with hearing loss.

The Newborn Hearing Screening Program will also sponsor the fourth bi-annual Delaware's Still Listening Conference in the Spring of 2010. This conference is designed for parents, professionals and community members to advance the mission of universal newborn hearing screening. The focus of the 2010 conference will be early intervention.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	8.2	8.2	8	8	12

Annual Indicator	8.5	12.6	12.3	12.3	10.5
Numerator	17045	25484	24992	24992	
Denominator	200527	202255	203188	203188	
Data Source					Kids Count Fact Book, 2009
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	10	10	10

Notes - 2008
Center for Applied Demography and Survey Research (Three year average 2006-2008).

Notes - 2007
Source: Delawareans Without Health Insurance, Univerisity of Delaware, 2006.

Notes - 2006
Source: Delawareans Without Health Insurance, Univerisity of Delaware, 2006.

a. Last Year's Accomplishments
Based on 2006-2008 data, 10.5% of children 0-17 are without health insurance. This is slightly lower than the national 11.3%. However, the percent of uninsured children has increased from the all-time low of 7% in 2000-2002.

As of 2008, there are 5,571 children enrolled in the Delaware Healthy Children Program (Delaware's CHIP). This program offers the benefits of most private health insurance plans, including routine check-ups, eye exams, dental care, physician care and hospitalization coverage. The challenge remains that not all children eligible for the Delaware Healthy Children Program are enrolled.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Community Health Access Program (CHAP) helps provide access to primary care doctors, medical specialists, and other health resources. Medical services are provided through Community-based Health Centers and private doctors.	X	X		
2. MCH Programs provice SCHIP and Medicaid eligibility determination and referrel.		X		
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
HB 22: Extends CHIP coverage to families with incomes up to 300% FPL. This increase (level is currently 200%) will allow families with higher income to qualify for the program.

c. Plan for the Coming Year
See attached resource guides in English and Spanish. We will continue to direct uninsured families and children to appropriate resources in the community for access to primary care and medical homes. Our efforts will particularly focus on utilization of Federal Qualified Health Centers located throughout the state.
An attachment is included in this section.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			33	33	20
Annual Indicator		34.0	27.8	28.4	20.2
Numerator		2141	2712	2814	2075
Denominator		6296	9763	9920	10264
Data Source					Delaware WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	18	18	17	17

Notes - 2006
2006 Delaware WIC program data.

a. Last Year's Accomplishments
The Maternal and Child Health program includes nutritionists in clinic-based services, as well as through contractual preconception and prenatal services. The ECCS program collaborates with Nemours Health and Prevention services on a number of issues related to school readiness and early childhood. One of Nemours' health priorities is early childhood obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Division of Public Health MCH programs partner with Nemours				X

Health and Prevention Services on child health issues including obesity prevention.				
2. The DPH Health Promotion and Prevention Section has obesity prevention as a strategic objective.				X
3. Nutritionists are part of the MCH programs' staff. These programs include Smart Start, Kids KARE, the Family Practice Team Model and Preconception Health Care.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH Program, the ECCS Program and Health Promotion and Disease Prevention combined efforts to provide funding and support for the development of educational modules for early education providers designed to prevent obesity among young children. This contract with the University of Delaware's Cooperative extension
will develop and conduct a professional development training to licensed child care providers. The training will focus on implementing new child care regulations related to obesity prevention (reduce screen time, increase healthy eating, and increase physical activity).

c. Plan for the Coming Year

Once the obesity module for early child case professional development has been created, the Early Childhood Comprehensive Systems project will utilize Nurse consultants to provide the training to early childhood care providers.

Childhood obesity has been identified as a new State performance measure and priority during FY 2009 and the MCH program is currently considering additional initiatives around this issue, including the additional promotion of breastfeeding.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			11	10.9	6.5
Annual Indicator		11.2	6.8	6.8	6.8
Numerator		1272	814	814	814
Denominator		11337	11898	11898	11898
Data Source					Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.6	6.4	6.4	6.4	6.2

Notes - 2008
2008 data is not available at this time.

Notes - 2007
2007 data are not available at this time.

Notes - 2006
2006 data are not available. 2006 reported rate is based on 2005 Delaware Vital Statistics, "Women who smoked during pregnancy."

a. Last Year's Accomplishments
Smoking has decreased among pregnant women in Delaware to 9.4% overall, and 10.1% among white women and 8.5% among black women. Although the prevalence of smoking during pregnancy has slightly decreased over time, white women consistently smoke more than average in Delaware.

Smoking cessation among pregnant women continues to be a focus of Smart Start, nurse home visiting program for high risk pregnant women, and the Infant Mortality Initiative Program that provides enhanced prenatal care. Women are referred to the well-established and widely recognized DPH Tobacco Prevention and Control services of Quitline and Quitnet. Through the Quitline women can access 24-hour counseling and advice from local experts. Free nicotine replacement therapy is available for those who qualify. Quitnet provides cessation information and assistance via the web.

Smoking cessation is also promoted through WIC, which serves more than half of all pregnant women in the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Smoking cessation continues to be a main risk factor reduction priority in each of the Maternal and Child Health program. Women are provided counseling and educational materials to assist in smoking cessation.	X	X		
2. The MCH programs refer women to the Delaware Quitline, a statewide resource that offers support, counseling and vouchers for pharaceutical products.	X	X		
3. Smoking during pregnancy contines to be monitored through the Registry for Improved Birth Outcomes.				X
4. The Delaware Healthy Mothers and Infants Consortium partners with community agencies to address the reduction of tobacco use among pregnant women and women of childbearing age.		X	X	X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The comprehensive smoking cessation programs and services are having an impact of Delaware women. Preliminary (not a full year of data) Delaware PRAMS suggests smoking decreased by 7.5% among women who smoked during the three months before pregnancy compared with women who were smoking during the last three months of pregnancy (20.5% 3 months before; 13% last 3 months).

c. Plan for the Coming Year
Collect individual-level data on pregnant women served through the Infant Mortality Initiative enhanced prenatal care program. By assess individual risks, such as tobacco use, and access to services, the success of tobacco cessation among Delaware's highest risk women can be assessed.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.5	5.5	5.5	5.4	5.4
Annual Indicator	8.4	5.8	13.5	13.5	13.5
Numerator	14	10	8	8	8
Denominator	166957	170943	59228	59228	59228
Data Source					Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	12.5	12	11.5	11

Notes - 2008
2008 data not available at this time.

Notes - 2007
2007 data not available at this time.

Notes - 2006
2006 Delaware Vital Statistics.

a. Last Year's Accomplishments

The School-Based Health Centers (SBHC) located in almost all high schools statewide serve as the conduit for a great majority of adolescent mental health services. Through the use of standardized screening, clinicians assess youth risk for mood disorders, substance abuse and suicidal ideation. In FY 08, there were 32,685 youth visits to SBHC for mental health services. The mental health visits constitute over 57% of all SBHC visits. The total number of mental health visits declined slightly from the previous year, FY 07, due to decreases in overall SBHC budgets that limited the number of mental health service hours provided.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DPH clinic based services provide referral for depression and other mental health conditions.		X		
2. School-Based Health Centers provide mental health counseling and referral to students.	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A statewide summit was held in November 2008 to convene stakeholders vested in improving the health of adolescents, including their mental health. During the summit, it was clear that mental health and nutrition (to address obesity epidemic) are the two most important services offered by SBHC. Due to this commitment and ever-shrinking state support for SBHC, the adolescent health program within DPH is working on a new model of services that decreases traditional clinical care in order to increase funding for mental health services. The new model of service will also emphasize the need to look outside of conventional reimbursement mechanisms to explore the feasibility of receiving reimbursement from private 3rd party payors. Currently, only Medicaid reimburses for SBHC services. Increased revenue will ensure continued viability of mental health services for youth.

c. Plan for the Coming Year

Implement a new model of SBHC services that provides more access to mental health services.

Explore group sessions for socio-emotional health. Examine the cost benefit of providing certain mental health services in this fashion.

Explore increased 3rd party reimbursement for SBHC services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	90	90	90	80

Annual Indicator	79.7	79.7	79.3	79.3	79.3
Numerator	145	145	188	188	188
Denominator	182	182	237	237	237
Data Source					2006 Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	82	82	84

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available at this time.

a. Last Year's Accomplishments
The Delaware Healthy Mothers and Infant Consortium's Standards of Care Committee reviewed the standards fo care, which included the American College of Obstetricians and Gynecologists state and national recommendations. The committee also reviewed the statewide Neonatal Transport Program. Delaware has only 1 Level III facility, Christiana Care, in New Castle County. Babies in need of Level III care must be transported to New Castle County. The evaluation of transportation systems is ongoing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Delaware Healthy Mothers and Infants Consortium, Standards of Care Committee monitors neonatal transport issues regarding transportation to the Level III facility.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During the past year the Standards of Care Committee, part of the Delaware Healthy Mothers and Infants Consortium, completed an update of the Inter-hospital Transport of Obstetrical/Neonatal Patients for the Clinical
Practice Guidelines section of the Standards of Care Manual for physicians and hospitals in Delaware.

c. Plan for the Coming Year
The Standards of Care Committee will continue to monitor neonatal transport issues in the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	88	90	90	90	75
Annual Indicator	84.7	83.2	73.9	73.9	73.9
Numerator	9615	9450	8796	8796	8796
Denominator	11358	11358	11898	11898	11898
Data Source					Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	77	77	80	80

Notes - 2008
2008 data not available at this time.

Notes - 2007
2007 data are not available at this time.

Notes - 2006
2006 data are not available. 2006 reported percentage is provisional and based on the 2005 data.

a. Last Year's Accomplishments
For the first time in over a decade, the percent of Delaware mothers who received prenatal care in the first trimester decreased in all counties, though prenatal attainment in the rural part of the state (Sussex County) had been decreasing since 1998-2002. The proportions of prenatal care attainment ranged from 26.2 percent of Hispanic mothers under 20 in Sussex County, to 92.7 percent of white mothers 30 and over in metropolitan area (New Castle County).

Given the relatively high proportion of Hispanic women residing in rural Sussex County and limited access to OB/GYN services, the Infant Mortality Elimination Initiative's enhanced prenatal care program expanded to include the only Federally Qualified Health Center in Sussex County -- La Red. In FY 2008, La Red served 505 pregnant women, the majority of which were Hispanic.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Smart Start and the Family Practice Team Model engage women in early pregnancy, and provide case management and follow-up services to ensure prenatal care is available and accessible.		X		
2. Prenatal programs provide translation services to non-English speaking women to reduce barriers to care.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The two main Infant Mortality Elimination Initiative's that provide direct patient care (preconception and prenatal care) are being combined into one comprehensive program -- Healthy Women/Healthy Babies (HWHB). The HWHB program will reimburse for enhanced prenatal care services for women at risk for poor birth outcomes, including those who are uninsured. Since inability to pay is a barrier to early prenatal care, HWHB will eliminate this barrier by reducing the economic burden on pregnant women and their families.

c. Plan for the Coming Year

Fully implement HWHB and assess rates of early entry into prenatal care by geographic region. Work with the Sussex County site, La Red, to increase outreach to women and education about the necessity for early prenatal care.

D. State Performance Measures

State Performance Measure 11: *The rate of infant deaths between birth and 1 year of life.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective					
Annual Indicator			8.3	8.3	8.3
Numerator			99	99	99
Denominator			11898	11898	11898
Data Source					Delaware Vital Statisitics
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	8	7.8	7.8	7.8

Notes - 2008

2008 data are not available at this time.

Notes - 2007
2007 data are not available at this time.

Notes - 2006
2006 Vital Statistics

a. Last Year's Accomplishments
Delaware's 5-year average infant mortality rate has declined from 9.2 deaths per 1000 live births in 2001-2005 to 8.8 deaths per 1000 births in 2002-2006 (the latest for which statistics are available). Although still higher than the U.S. rate, this decrease is greater than observed nationally.

State support remains strong for the work of the Delaware Healthy Mother and Infant Consortium (DHMIC). Even with the state budget crisis, funds for infant mortality elimination received only a minor cut in comparison with other programs. Funding for core initiatives remains strong at 5.3 million per year.

Delaware knows more now about the causes of infant mortality than ever before. This is due in main part to the work of the Center for Family Health Research and Epidemiology (Center) located within DPH. The Center conducted a Perinatal Periods of Risk (PPOR) assessment in fall 2008. Highlights include:
- Maternal health and prematurity contribute to excess infant mortality.
- Maternal complications of pregnancy are the second-leading cause of death among African-Americans.
- Disparities persist among African American women and those residing in rural areas.
- Infant health should be examined further in the rural county of Delaware.
PPOR along with analysis of linked birth and death records will be used to continue targeting interventions to increase preconception care, interconception care and enhanced prenatal care among all women, especially those at risk of poor birth outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Statewide preconception campaign. Over 15,000 women served in FY 08. This program has aspects that cut across all four levels of the MCH pyramid.	X	X	X	X
2. Statewide enhanced prenatal care program targeting high-risk women. This program affects nearly 20% of all Delaware pregnancies. This program has aspects that cut across all four levels of the MCH pyramid.	X	X	X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The preconception and enhanced prenatal care program known as Family Practice Team Model, is being combined into one program. This program will be called Healthy Women/Health Babies (HWHB). HWHB will use the life course model and incorporate a stronger focus on

interconception care.

The CDC MCH epidemiology assignee returned to CDC in May 2008. As of June 2008, DPH has contracted with APS Health care to provide epidemiology, research and evaluation services for the family health programs within DPH. A large emphasis will be placed on research, analysis and evaluation of infant mortality elimination initiatives and those that target overall improvements in women's health before pregnancy -- preconception.

c. Plan for the Coming Year
PPOR phase II will be conducted. Based on the initial findings, researchers will conduct a detailed examination of the maternal health and prematurity component for each of the three counties and for African American women in all regions. Additional analyses of maternal care for black women throughout the state and infant care in Kent and Sussex Counties will be performed.

Fetal death study. DPH will examine whether actual fetal deaths are misclassified as live births. The literature on fetal death analyses indicates that in addition to problematic data collection issues, the actual definition of fetal deaths vary by state. A cross-sectional, population-based sample will be taken of a minimum of five years of fetal death/stillbirth data and validated with maternal medical records.

State Performance Measure 12: *The rate of live births at 32 to 36 weeks of gestation(preterm birth).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator			112.4	112.4	112.4
Numerator			1337	1337	1337
Denominator			11898	11898	11898
Data Source					Delaware Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	110	108	106	104	102

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available at this time.

Notes - 2006
2006 Vital Statistics

a. Last Year's Accomplishments
One of the Delaware Healthy Mother and Infant Consortium (DHMIC) initiatives includes an intervention with women most at risk for prematurity. The Prematurity Prevention Program provides progesterone therapy to women at risk for premature delivery. Of the 54 women who delivered babies in FY08, 61% avoided premature labor and deliveries.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prematurity Prevention Program that provides women with a history of prematurity access to progesterone therapy.	X			
2. Statewide enhanced prenatal care program targeting high-risk women. This program affects nearly 20% of all Delaware pregnancies. This program has aspects that cut across all four levels of the MCH pyramid.	X	X	X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Planning is underway to develop a prematurity awareness campaign targeted towards African American women of reproductive age. In order to reduce the number of infant deaths in Delaware, the number of premature births must be reduced. The awareness campaign will target the following misconceptions:

- Prematurity isn't that bad.
- Small babies do just fine in the NICU.
- Having a baby born before 40 weeks is easier on the mom.
- It is chic or cute to have a really small baby.

c. Plan for the Coming Year

Stronger outreach will made among monolingual Spanish speaking women to ensure those with a history of premature delivery are able to take advantage o the Prematurity Prevention Program.

The prematurity awareness campaign will be fully implemented via print, radio and television

State Performance Measure 13: *The rate of low birth weight and very low birth weight deliveries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective					
Annual Indicator			94.0	94.0	94.0
Numerator			1119	1119	1119
Denominator			11898	11898	11898
Data Source					Delaware Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	92	90	88	86	84

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available at this time.

Notes - 2006
2006 Vital Statistics

a. Last Year's Accomplishments
Initiatives to reduce LBW/VLBW targeted smoking and substance abuse during pregnancy. Smoking contributes for 20-30% of all low birth weight deliveries nationwide. Maternal smoking is addressed by the enhanced prenatal care program, Family Practice Team Model. Women are referred to the state's tobacco Quitline or internet-based, Quitnet. Motivational interviewing and Stages of Change counseling is also used to encourage smoking and substance abuse cessation. Out of the 1,707 infant deliveries among women in the Family Practice Team Model program, 92% delivered a normal birth weight infant.

In FY08, the number of pregnant women served by the Family Practice Team Model increased by 90% compared to FY07. This program disproportionally serves African American and Hispanic women, given they are at increased risk of poor birth outcomes, including LBW/VLBW deliveries.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Statewide enhanced prenatal care program targeting high-risk women. This program affects nearly 20% of all Delaware pregnancies. This program has aspects that cut across all four levels of the MCH pyramid.	X	X	X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The prematurity awareness campaign mentioned under state performance measure #2 will also affect LBW/VLBW.

Support of the efforts of the Tobacco Prevention and Control Program to ensure all pregnant women have access to tobacco cessation counseling and services.

c. Plan for the Coming Year

Implementation of the prematurity awareness campaign.

Expansion of the Family Practice Team Model within the new Healthy Women/Healthy Babies program.

State Performance Measure 14: *The percent of children and adolescents who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator				17	17
Numerator					
Denominator					
Data Source					Delaware YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16	16	15	15	14

Notes - 2008
2007 YRBS

Notes - 2007
2007 YRBS

Notes - 2006
Performance measure was added in the 2010 application. Latest available data are from the 2007 YRBS.

a. Last Year's Accomplishments
Although DPH did not receive Physical Activity, Nutrition and Obesity (PANO) funding through the competitive CDC application in 2008, the PANO program within the DPH Health Promotion and Disease Prevention Section has moved forward with limited state funding to develop and implement a statewide plan. The goals are to:

- Increase physical activity
- Increase the consumption of fruits and vegetables
- Decrease the consumption of sugar-sweetened beverages
- Increase breastfeeding initiation and duration
- Reduce the consumption of high-energy-dense foods
- Decrease television viewing

Work began on the plan with the establishment of a statewide PANO coalition. The coalition has established seven committees/workgroups. These include:

- Community-based programs
- School/Youth
- Environment
- Industry/Employee Health
- Policy and Legislation

- Health Care Delivery
- Research and Evaluation

In FY 09, there were 3,629 registrants enrolled in the Lt. Governor's Challenge and 1,879 completed the Challenge. The goal of the Lt. Governor's Challenge is to motivate Delawareans to become more active and to make the First State the "Fit State". The Lt. Governor's Office has teamed up with the American Cancer Society, Christiana Care Health Systems, Division of Public Health, University of Delaware, YMCA and the Delaware State Chamber of Commerce to develop and promote this free program. The goal is to get Delawareans started toward a more active lifestyle. The program offers a framework for Delawareans to become more physically active, and a variety of activities that will earn you points towards a Lt. Governors Challenge achievement medal. Since inception, there has been 45,657 registrants and 19,351 completed the Lt. Governor's Challenge program

The Lt. Governor's Challenge partners with a larger social marketing campaign to promote fitness called "Get up and Do Something". The Get up and Do Something campaign is composed of multimedia messages and informative website that offers tips and strategies to increase physical activity.

Additional PANO accomplishments include:

- Published Healthy Communities: A Resource Manual for Delaware Communities.
- Awarded a grant from the National Association of Chronic Disease Directors to provide community mini-grants to promote healthy eating and active living.
- Completed production on the new ad for Get up and Do Something. The new ad was developed based on the video contest winner of 2008. This new ad, themed Couch Busters, was aired in February 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Establishing a statewide PANO coalition				X
2. Governor's Challenge			X	
3. Get Up and Do Something Campaign			X	
4. MCH and Health Disease Prevention and Promotion are collaborating on an early childhood obesity prevention initiative that will provide an educational module for early childhood educators for use in day care and early education settings.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PANO coalition under the direction of the PANO Program Administrator is working to complete the state plan. Completion is expected by late 2009.

Additional PANO activities include:

- Working with the University of Delaware to incorporate healthy living strategies through land use design and policy into local government trainings at the Institute for Public Administration.
- Meeting with various state agencies in starting a farmer's market aimed at state

employees. This pilot project will integrate health and agriculture sustainability education into the farmer's market.

c. Plan for the Coming Year
A needs assessment specific to school-aged children is one of the PANO coalition goals. The MCH program plans to partner with the coalition to conduct a needs assessment of the status of school-age children and youth as it relates to nutrition, physical activity, obesity and overweight. Work will begin on the needs assessment in November 2009.

Operationalize a weekly farmer's market in the green space near the state legislative building.

State Performance Measure 15: *The percent of women of childbearing age (15-44) who are obese (BMI 30 or higher).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective					
Annual Indicator				27	27
Numerator					
Denominator					
Data Source					Delaware BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26	26	25	25	24

Notes - 2008
Percent of women 25-34, 2007 YRBS

Notes - 2007
Percent of obese women 25-34, 2007 YRBS.

Notes - 2006
Performance measure was added in the 2010 application. Latest available data are from the 2007 BRFSS.

a. Last Year's Accomplishments
The work of the PANO program in DPH and the establishment of a statewide PANO coalition (mentioned in SPM#4) positively impacts SPM#5. Achieving the goals of the coalition will positively impact the health of all Delawareans, including women of reproductive age.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nutritional counseling for preconception women and women in prenatal care.	X			
2. Nutritional counseling for youth in School Based Wellness Centers.	X			

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Infant Mortality Elimination program and DHMIC are working to develop a preconception social marketing campaign. A significant message of the campaign is the need to achieve a healthy weight before pregnancy. Novel messaging and distribution via new media (e.g. text messaging, blogs) will promote widespread dissemination of this message to women of childbearing age.

In addition, the preconception program and enhanced prenatal care program provide nutritional counseling to all overweight and obese women. The women are eligible to meet with a Registered Dietician within their current care setting to develop individual healthy eating and healthy weight goals. Impact evaluation on an individual-level will take place during the upcoming year.

c. Plan for the Coming Year
-Implement the preconception social marketing campaign.
-Work with the PANO program to identify systemic changes that impact obesity among women of childbearing age.
- Evaluate changes in BMI among women participating in the Healthy Women/Healthy Babies program.

State Performance Measure 16: *The mortality rate among children and youth (0-21 years) due to unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator				16.1	16.1
Numerator					
Denominator					
Data Source					Hospital Discharge Data
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.5	10.5	10	10.5	10.5

Notes - 2008
Five year rate, 200-2006

Notes - 2007
Five year rate, 2002-2006

a. Last Year's Accomplishments
Safe Kids is sponsored by a grant through State Farms insurance. Safe Kids provides education events and "Safe Kids Days". Each of the three Safe Kids Days brings together safety and injury prevention organizations throughout the state to provide safety information to children and their families in a fun and interactive environment. Each Safe Kids Day features activities such as a fire safety smoke house, and tables focusing on water/boat safety, archery safety, home safety, and poison prevention education. Families also have access to interactive bike safety rodeos, and the State Police "Convincer". Each Safe Kids Day includes a car seat check up event. At each event an average of 25 seats are checked, totaling 75 seats for the three safety days.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Injury Prevention Coalition, a group consisting of many state and community-based agencies, continues to promote injury prevention awareness throughout the state.			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
DPH does not have an injury or violence prevention program. The Emergency Medical Services for Children program focuses services for injured children but does not address childhood injury prevention. The Delaware Injury Prevention Coalition is composed of stakeholders from law enforcement, hospitals, advocacy groups, physicians, nurses, domestic violence advocates and fire prevention. The Coalition is led by the Office of Emergency Medical Services. Although the Injury Prevention Coalition is doing excellent work with relatively no budget, they do not have a focus of childhood injury prevention. Their focus thus far has been on adults, namely falls among the elderly. The Child Death Review Commission assess the impact of injuries and accidents but does not include a prevention component. Safe Kids Delaware offers educational events throughout the year, however, there is no comprehensive statewide initiative to reduce childhood injuries.

By making it a new state priority, child/youth injuries will receive a higher level of visibility and will become a priority project for the MCH Director. Fertile ground already exists in the excellent working relationship between MCH, Emergency Medical Services for Children and Child Death Review. By building on this partnership and working with the vested stakeholders on the Delaware Injury Prevention Coalition, a new initiative will be built during 2009-2010 to address this important area of child health.

c. Plan for the Coming Year

DPH MCH Program in partnership with the DPH Emergency Medical Services for Children Program, Safe Kids, Child Death Review and Injury Prevention Coalition will work on an injury prevention needs and resources assessment. DPH MCH will reach out the Children's Safety Network for technical assistance in conducting the needs assessment. Based on the findings and a thorough epidemiologic analysis, goals and objectives will be identified to address unintended injuries in the child and adolescent population. Prevention of deaths due to motor vehicle accidents will be a critical goal given that they were the leading cause of injury deaths (1996-2002) for those 0-19 years of age.

State Performance Measure 17: *The percent of Delaware public high school students who currently smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective					
Annual Indicator			18.2	18.2	19.1
Numerator					
Denominator					
Data Source					Delaware YRBS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	10	10	10

Notes - 2008
2008 YRBS

Notes - 2007
2007 YRBS

Notes - 2006
2007 YRBS

a. Last Year's Accomplishments
Teens Against Tobacco Use (TATU) is a curriculum that trains adult facilitators and high school aged teens on tobacco prevention. The trained teens then take the program to middle schools and other community settings to work with younger children; Delaware Kick Butts Generation (KBG) is a program that empowers youth to develop and maintain groups in schools and communities to work on tobacco issues that are relevant to their environment. Not-On-Tobacco (N-O-T) is a smoking cessation program designed for youth that is gender specific to help them quit smoking.

- 17,780 youth and adults participated in the community outreach programs. Another 225,000 potentially viewed anti-tobacco messages produced through community outreach.
- "Anti-Ash Brigade" (AAB) program reached 3,560 youth.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**

1. Teens Against Tobacco Use training and public education.			X	
2. Delaware Kick Butts Generation youth empowerment programs.		X		
3. Youth tobacco cessation program.		X		
4. Quitline and Quitnet tobacco cessation programs.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This year to date, schools have reached 14,500 youth in the TATU program, 51 in NOT and 27,500 in the KBG program. Another 27,700 adults and youth saw billboards or read a newsletter produced through the youth prevention program.

In June 2009, a new bill (HB211) was introduced to the tobacco excise tax by 45 cents. Increases in excise tax have been shown to reduce youth smoking.

c. Plan for the Coming Year
New campaign addressing 18-24 year olds will address smoking initiation among young adults, especially those in college.

State Performance Measure 18: *The percent of benchmark measures completed for implementation of a formal umbrella structure for organizations serving families with children with special health care needs in Delaware.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator					20.0
Numerator					1
Denominator					5
Data Source					State Title V Program Data
Is the Data Provisional or Final?					Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	80	100	100	100

a. Last Year's Accomplishments
This is a new initiative that started in Federal Fiscal Year 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V and the Delaware Children with Special Health Care Needs program is working toward the implementation of an overarching organization to promote collaboration and increase				X

the efficiency and effectiveness of family-focused groups and organizat				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During the current year, the Title V, Children with Special Health Care Needs program convened a group of stakeholders from throughout the state to complete key informant interviews and identify specific needs in supporting family organizations throughout the State. In the spring and early Summer of 2009, the initial planning stage was completed and a request for proposals (RFP) was being prepared.

c. Plan for the Coming Year
A request for proposals will be issued in Fall, 2009. It is anticipated that the successful bidder will enter into contract negotiations in January 2010. Upon contract execution, a formalized governance structure will be implemented (executive and advisory boards), policies and procedures will be drafted, and work will be initiated on a strategic plan (including identification of funding streams).

State Performance Measure 19: *The percentage of children aged 4 months to 5 years with no or low risk for developmental, behavioral or social delays.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator					74
Numerator					
Denominator					
Data Source					NSCH, 2007
Is the Data Provisional or Final?					Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	76	76	78	78	80

Notes - 2008
2007 National Survey on Children's Health

a. Last Year's Accomplishments
This is a new state performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Early Childhood Comprehensive Systems initiative collaborates with partners throughout the state to strengthen				X

available early childhood developmental screening and interventions in a number of settings.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Early Childhood Comprehensive Systems initiative is continuing to work with the Delaware Chapter of the American Academy of Pediatrics and other state partners to expand developmental comprehensive screening among both pediatric and primary care practice sites. This is an expansion of the Assuring Better Child Health and Development project from the Commonwealth Fund.

A new law that was supported by the Lt. Gov. (HB 199) requires that private insurance companies reimburse for developmental screens during well child visits.

c. Plan for the Coming Year
The Early Childhood Comprehensive Systems (ECCS) initiative will continue to work the the Delaware Chapter of the American Academy of Pediatrics and other partners toward a statewide implementation of developmental screenings using a validated screening tool.

The ECCS program will work to expand PCIT (Parent Child Interaction Therapy) in child care settings and early childhood educational settings.

The ECCS program will work with Nemours Health and Prevention Services to implement statewide training for the Triple P - Positive Parenting Program - among professionals serving parents.

The ECCS program is planning a comprehensive evaluation of the components of the program including parental surveys and development of indicators for the birth to 8 population, including children with special health care needs, across the five identifed ECCS domains (access to health insurance and medical homes; early care and education; mental health and social, emotional health; parenting education; and family support).

E. Health Status Indicators

Introduction
As a leading contributor to infant mortality, Delaware has focused its efforts on reducing the number of low birth weight and very low birth weight infants. The Infant Mortality Initiative supports an enhanced prenatal care program for at risk women. Since 2007, the program has extended to sites throughout the state, including a larger urban OB/GYN practice that serves primarily African American women. The enhanced prenatal care focuses on providing high-quality holistic medical, social, nutrition and mental health services. Risk behaviors that impact birth weight include smoking while pregnant. In 2006, 13.9 percent of Delaware women who smoked while pregnant gave birth to low birth weight babies (< 2500 grams), versus the significantly lower percentage (8.8) of non-smokers who gave birth to low birth weight babies. The

program focuses on smoking cessation through using the Delaware Quitline and Quitnet.

Reducing the number of low and very low birth weight infants will remain of primary focus in FY10. This includes a media campaign focused on enhancing awareness about the dangers of prematurity and expanding the number of women served through the enhanced prenatal care program. More work is needed in this area since the percent distribution of births by birth weight has not differed significantly between 1990 and 2006.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.0	9.0	9.3	9.3	9.3
Numerator	1024	1024	1112	1112	1112
Denominator	11358	11358	11898	11898	11898
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available.

Narrative:
As a leading contributor to infant mortality, Delaware has focused its efforts on reducing the number of infants born below 2,500 grams. The Family Practice Team Model, a comprehensive prental case management program, was implemented in 2007. Preconception healthcare services for at-risk women throughout the state are also made available. Both of these progams are part of the State Infant Mortality Elimination initiative.

Targeting women who have already had a poor birth outcomes, such as a low/very low birth weight, will be aided by utilizing data from the Registry for Improved Birth Outcomes. This registry is a list of all women who gave birth between 1989 and 2004 (most recent data) who had a poor birth outcome. Analysis from the Registry reveals that of the 2,297 women experiencing there second poor birth outcome, 1,918 (84%) delivered a premature infant. This represents a 4% increase in premature birth from the first poor birth outcome (removing multiples).

Based on this data, focusing on women who have already had a low/very low birth weight infant will be of primary importance for the enhanced prenatal care program.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.0	9.0	7.3	7.3	7.3
Numerator	1024	1024	833	833	833
Denominator	11358	11358	11452	11452	11452
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available.

Notes - 2006
2006 Provisional data is the 2004 actual births 2500 grams or less. 2006 data are not available at this time.

Narrative:
As a leading contributor to infant mortality, Delaware has focused its efforts on reducing the number of infants born below 2,500 grams. The Family Practice Team Model, a comprehensive prental case management program, was implemented in 2007. Preconception healthcare services for at-risk women throughout the state are also made available. Both of these progams are part of the State Infant Mortality Elimination initiative.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.6	1.6	2.0	2.0	2.0
Numerator	182	182	237	237	237
Denominator	11358	11358	11898	11898	11898
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available.

Narrative:

As a leading contributor to infant mortality, Delaware has focused its efforts on reducing the number of infants born below 2,500 grams. The Family Practice Team Model, a comprehensive prental case management program, was implemented in 2007. Preconception healthcare services for at-risk women throughout the state are also made available. Both of these progams are part of the State Infant Mortality Elimination initiative.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.6	1.6	1.5	1.5	1.5
Numerator	182	182	175	175	175
Denominator	11358	11358	11452	11452	11452
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available.

Notes - 2006
2006 Provisional data is the 2004 actual births 2500 grams or less. 2006 data are not available at this time.

Narrative:
As a leading contributor to infant mortality, Delaware has focused its efforts on reducing the number of infants born below 2,500 grams. The Family Practice Team Model, a comprehensive prental case management program, was implemented in 2007. Preconception healthcare services for at-risk women throughout the state are also made available. Both of these progams are part of the State Infant Mortality Elimination initiative.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.0	8.0	8.0	8.0	8.0
Numerator	66	66	11	11	11
Denominator	826523	826523	137313	137313	137313
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Data are provisional and based on 2006 data.

Notes - 2006
2006 Vital Statistics (This is a one year rate. Prior to this year rate was reported as a five year average rate).

Narrative:
The 2002-2006 five-year unintentional injury mortality rate for the 0-4 age group is 10.9. The rate for the 5-14 year old age group is 4.0. The rates for both groups have decreased over time. For the 5-14 year group the rate has decreased by half when compared to 1998-2002.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	3.1	3.1	3.6	3.6	3.6
Numerator	26	26	5	5	5
Denominator	826279	826279	137313	137313	137313
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available at this time.

Notes - 2006
2006 Vital Statistics

Narrative:
The 2002-2006 proportion of unintentional injury deaths due to motor vehicle accidents for the 0-4 and 5-14 age groups is 33.3 and 40.9 respectively. The proportion of deaths has decreased for

the 0-4 age group when compared to 2001-2005. The proportion of deaths has increased for the 5-14 age group when compared to 2001-2005.

The Office of Highway Safety continues to focus on child passenger safety through the safety technician program and child restraint fitting stations.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	33.5	33.5	25.7	25.7	25.7
Numerator	38	38	21	21	21
Denominator	113580	113580	81711	81711	81711
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available.

Notes - 2006
2006 Vital Statistics, Motor Vehicle Deaths to 15-21 year olds.

Narrative:
The 2002-2006 proportion of unintentional injury deaths due to motor vehicle accidents for the 15-21 age group is over 80%. This is a slight increase compared to 1998-2002.

In FY 2009 the Office of Highway Safety will be implementing, among others, the following initiatives in order to impact motor vehicle crashes on Delaware roadways:
• Click it or Ticket enforcement and public awareness campaigns in February and May 2009
• Checkpoint Strikeforce and national DUI crackdown enforcement and public awareness campaigns in summer 2009
• Stop Aggressive Driving/speed enforcement and public awareness campaign in summer 2009
• Tween seat belt use initiatives aimed at increasing seat belt use among 9-13 year old children
• Teen driving initiatives, including Parent Orientation Programs in high schools that outline requirements for parents and their children taking driver's education
• Speed Management Workshop development at the local level
• Statewide Highway Safety Conference for our highway safety partners in October 2008
• Work with the State Motorcycle Rider Education Committee on initiatives to improve motorcycle safety

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.0	9.0	9.0	9.0	9.0
Numerator	15	15	15	15	15
Denominator	166977	166977	166977	166977	166977
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available. Reported rate is from 2005 Hospital Discharge data.

Notes - 2007
2007 data are not available. Reported rate is from 2005 Hospital Discharge data.

Notes - 2006
2006 Data Not Available. Reported rate is from 2005 Hospital Discharge data.

Narrative:
More than three-quarters of children's injury hospitalizations occur unintentionally. This has remained consistent over time, with 2,124 pediatric patients from 1996-1999 (81.8%) and 2,127 from 2002-2005 (85.9%).

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.0	9.0	9.0	9.0	9.0
Numerator	15	15	15	15	15
Denominator	166977	166977	166977	166977	166977
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

2008 data are not available. Reported rate is from 2005 Hospital Discharge data.

Notes - 2007
2007 data are not available. Reported rate is from 2005 Hospital Discharge data.

Notes - 2006
2006 data are not available. Reported rate is from 2005 Hospital Discharge data.

Narrative:
Motor vehicle accidents and falls account for the majority of non-fatal injuries among pediatric patients. The work of the Office of Highway Safety is intended to impact injuries (fatal and non-fatal among all populations).

In FY 2009 the Office of Highway Safety will be implementing, among others, the following initiatives in order to impact motor vehicle crashes on Delaware roadways:
• Click it or Ticket enforcement and public awareness campaigns in February and May 2009
• Checkpoint Strikeforce and national DUI crackdown enforcement and public awareness campaigns in summer 2009
• Stop Aggressive Driving/speed enforcement and public awareness campaign in summer 2009
• Speed Management Workshop development at the local level
• Statewide Highway Safety Conference for our highway safety partners in October 2008
• Work with the State Motorcycle Rider Education Committee on initiatives to improve motorcycle safety

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	200.7	200.7	200.7	200.7	200.7
Numerator	228	228	228	228	228
Denominator	113580	113580	113580	113580	113580
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not available. Reported rate is from 2005 Hospital Discharge data.

Notes - 2007
2007 data are not available. Reported rate is from 2005 Hospital Discharge data.

Notes - 2006
2006 data are not available. Reported rate is from 2005 Hospital Discharge data.

Narrative:
In 1996-2005 there were almost four times the number of motor vehicle injuries compared to fall injuries among the teen/young adult age group.

In FY 2009 the Office of Highway Safety will be implementing, among others, the following initiatives in order to impact motor vehicle crashes on Delaware roadways:
• Tween seat belt use initiatives aimed at increasing seat belt use among 9-13 year old children
• Teen driving initiatives, including Parent Orientation Programs in high schools that outline requirements for parents and their children taking driver's education
• Speed Management Workshop development at the local level

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	33.9	36.8	37.8	34.0	36.6
Numerator	962	1064	1099	1000	1074
Denominator	28369	28935	29054	29397	29377
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Delaware STD Program

Narrative:
Cases of Chlamydia have increased in 2009 compared to 2008. The DPH STD program continues to promote safe sex practices and testing statewide. Free or reduced cost STD testing is available at all public health clinics. All 28 School-Based Wellness Centers also offer free STD testing and counseling.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.7	9.3	10.1	10.3	11.4
Numerator	1119	1351	1469	1499	1655
Denominator	146241	145668	145906	145178	145164
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
HIV/STD/HCV Program

Narrative:
Cases of Chlamydia have increased in 2009 compared to 2008. The DPH STD program continues to promote safe sex practices and testing statewide. Free or reduced cost STD testing is available at all public health clinics.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	11690	8230	3040	0	0	0	0	420
Children 1 through 4	46840	33010	12150	0	0	0	0	1680
Children 5 through 9	56290	38660	15010	0	0	0	0	2620
Children 10 through 14	56790	37230	16450	0	0	0	0	3110
Children 15 through 19	58830	41080	14970	0	0	0	0	2780
Children 20 through 24	57460	40090	14930	0	0	0	0	2440
Children 0 through 24	287900	198300	76550	0	0	0	0	13050

Notes - 2010

Narrative:
Population growth remains steady in Delaware and continuing to be racially diverse.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	10850	840	0
Children 1 through 4	43520	3320	0
Children 5 through 9	52130	4160	0
Children 10 through 14	52630	4160	0

Children 15 through 19	54670	4160	0
Children 20 through 24	54640	2820	0
Children 0 through 24	268440	19460	0

Notes - 2010

Narrative:
Approximately 7% of Delaware's population is Hispanic, which is less than the national percentage. However, the number of Hispanics, including children, has significantly increased over the last decade.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	25	12	12	0	0	0	0	1
Women 15 through 17	386	206	173	1	1	0	0	5
Women 18 through 19	870	519	338	3	2	1	0	7
Women 20 through 34	8981	6340	2179	32	381	6	0	43
Women 35 or older	1636	1205	320	4	95	2	0	10
Women of all ages	11898	8282	3022	40	479	9	0	66

Notes - 2010

Narrative:
Delaware's general fertility rate was 65.8 live births per 1,000 females aged 15-44 years in 2002-2006. However,
when broken down into specific age groups, birth rates and trends varied substantially; comparing birth rates in
1990-1994 and 2002-2006 displayed a shift toward older mothers in the distribution of birth rates.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	14	10	1
Women 15 through	300	85	1

17			
Women 18 through 19	680	185	5
Women 20 through 34	7522	1433	26
Women 35 or older	1482	153	1
Women of all ages	9998	1866	34

Notes - 2010

Narrative:
Delaware's general fertility rate was 65.8 live births per 1,000 females aged 15-44 years in 2002-2006. However,
when broken down into specific age groups, birth rates and trends varied substantially; comparing birth rates in
1990-1994 and 2002-2006 displayed a shift toward older mothers in the distribution of birth rates.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	99	50	44	0	0	3	0	2
Children 1 through 4	9	4	5	0	0	0	0	0
Children 5 through 9	11	9	2	0	0	0	0	0
Children 10 through 14	0	0	0	0	0	0	0	0
Children 15 through 19	92	60	31	0	0	1	0	0
Children 20 through 24	0	0	0	0	0	0	0	0
Children 0 through 24	211	123	82	0	0	4	0	2

Notes - 2010
This total is for Children 5-14.

This total is for Children 15-24.

Narrative:
The primary causes of infant mortality are birth defects, disorders related to short gestation/low birth weight, SIDS and issues related to pregnancy and birth, including substance abuse.

Unintentional injuries are a leading cause of death among children, youth and young adults.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	87	12	0
Children 1 through 4	7	2	0
Children 5 through 9	10	1	0
Children 10 through 14	0	0	0
Children 15 through 19	80	12	0
Children 20 through 24	0	0	0
Children 0 through 24	184	27	0

Notes - 2010
This total is for children 5-14.

This total is for Children 15-24.

Narrative:
The primary causes of infant mortality are birth defects, disorders related to short gestation/low birth weight, SIDS and issues related to pregnancy and birth, including substance abuse.

Unintentional injuries are a leading cause of death among children, youth and young adults.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	229849	158125	61110	0	0	0	0	10614	2008
Percent in household headed by single parent	33.0	19.9	57.5	33.0	33.0	33.0	0.0	33.0	2007
Percent in TANF (Grant) families	2.9	2.9	2.9	0.0	0.0	0.0	0.0	2.9	2007
Number enrolled in Medicaid	95253	64772	19050	0	0	0	0	11431	2007
Number	5069	3244	1014	0	0	0	0	811	2007

enrolled in SCHIP									
Number living in foster home care	959	565	353	41	0	0	0	0	2007
Number enrolled in food stamp program	94995	47961	45332	1702	0	0	0	0	2007
Number enrolled in WIC	39218	19609	14094	5311	0	204	0	0	2008
Rate (per 100,000) of juvenile crime arrests	2711.0	0.0	0.0	0.0	0.0	0.0	0.0	2711.0	2005
Percentage of high school drop-outs (grade 9 through 12)	5.4	4.3	7.0	5.4	5.4	5.4	5.4	0.0	2007

Notes - 2010
2008 Delaware Population Projections. These estimates only break population down by Black, White or Other.

Center for Applied Demography and Survey Research. Percent in household headed by single parent not reported by race.

Kaiser Family Foundation, (statehealthfacts.org).

Narrative:
Given the financial crisis and high unemployment in Delaware, there is the potential for increases in TANF, Medicaid, and WIC.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	208331	22771	0	2007
Percent in household headed by single parent	33.0	33.0	0.0	2007
Percent in TANF (Grant) families	2.9	2.9	0.0	2006
Number enrolled in Medicaid	90490	4763	0	2007
Number enrolled in SCHIP	4816	253	0	2006
Number living in foster home care	928	81	0	2007
Number enrolled in food stamp program	43896	3815	0	2007

Number enrolled in WIC	18792	817	0	2007
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2711.0	2005
Percentage of high school drop-outs (grade 9 through 12)	7.5	5.4	0.0	2007

Notes - 2010

Narrative:
Given the financial crisis and high unemployment in Delaware, there is the potential for increases in TANF, Medicaid, and WIC.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	72363
Living in rural areas	156189
Living in frontier areas	0
Total - all children 0 through 19	228552

Notes - 2010

Narrative:
The percentage of children and youth living in rural areas is higher than the percent living in urban areas. This poses challenges for access to care and availability of health care, including mental health providers.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	863900.0
Percent Below: 50% of poverty	7.5
100% of poverty	10.0
200% of poverty	27.0

Notes - 2010

Narrative:
The percentage of children and youth living in rural areas is higher than the percent living in urban areas. This poses challenges for access to care and availability of health care, including mental health providers.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	231200.0
Percent Below: 50% of poverty	0.0
100% of poverty	13.0
200% of poverty	20.0

Notes - 2010
Children 1-17 from the National Center for Children in Poverty.
http://nccp.org/profiles/DE_profile_7.html

The percent of children at or below 50% of federal poverty level is not known.

Narrative:
Economic hardship can have profound effects on children's development and their prospects for the future. Children most at risk for not achieving their full potential are those who live in poverty while very young and those who experience severe and chronic economic hardship. More than 27,000 children in Delaware, over 13% of children, living in families with incomes below the federal poverty level.

F. Other Program Activities

/2009/ In addition to the identified priority needs, National Performance Measures and State Performance Measures, DPH addresses a number of additional priority MCH health issues. These include HIV/AIDs, Cancer and Women's Health.

African American make up 65 percent of AIDS cases even though they are only 17 percent of Delaware's population. More than 50 percent of Delaware's HIV cases occur in Wilmington. This disparity is addressed by several programs.

DPH's Office of Minority Health has implemented a capacity building program in the African-American Community and Hispanic Communities, providing technical assistance to organizations, helping to establish effective HIV/AIDS outreach, education, counseling and testing programs.

DPH's HIV counseling and testing program places special emphasis on meeting the needs of the African-American community. The program targets youth, injected drug users, their partners, men who have sex with me and heterosexual women. Testing is provided in locations throughout the state.

Delaware has made great strides in reducing Delaware's cancer incidence and mortality rates. DPH offers a comprehensive program to educate residents and prevent cancer, monitor the number of cases, offer access to cancer testing and treatment and establish legislation that protects the public from risks. As mentioned earlier, in addition to infant mortality, health disparities and the reduction of cancer incidences are main priorities of the Governor. Delaware maintains an established cancer registry to report incidence and deaths by race, gender and age group. Education and prevention are offered through a nationally recognized anti-tobacco

program and the Delaware Quitline, a smoking cessation resource available statewide. The Screening for Life Program provides payment for cancer screening tests to qualified adults which includes office visits, mammograms, pap tests, colorectal cancer screening tests and health education and help with coordinating associated care. Over 40% of women receiving pap tests through the Screening for Life Program are Hispanic which speaks to the success of the program in reaching a disparate population. Care coordination is available to every person diagnosed with cancer in Delaware to find medical and support services. The Delaware Cancer Treatment program pays for treatment for any uninsured Delawareans diagnosed with cancer that are below 650 percent of the federal poverty level (an amount equal to an income of $122,525 for a famly of four).

The DPH Office of Women's Health sponsors an annual Women's Health Expo annually. This yearly event has been a successful due to partnerships with numerous organizatons throughout the State. In 2007, over 700 people attended the Expo. The Office of Women's Health is charged with:
• Formulating and implementing a women's health agenda with community leaders and organizations;
• Creating and strengthening partnerships to address key women's health concerns and promote disease prevention;
• Providing outreach and education regarding health promotion, disease prevention and management for women;
• Performing leadership development and community capacity building;
• Disseminating data and research relating to gender-specific health care and treatment outcomes; and
• Recognizing women's multiple, overlapping and sometimes conflicting social roles, and their knowledge and right to make decisions. //2009//

G. Technical Assistance

/2009/ While the past State's needs assessment process has been conducted in a multi-faceted manner (i.e., reviewing existing reports, surveys, careful examination of data, discussions with professional and community leaders and groups and clients), there is a need to more fully examine overall program capacity. The state is asking for technical assistance at this time to determine optimal staffing patterns in each of the state's Public Health Clinics' Maternal and Child Health Programs. As noted in the budget, there are currently 26.4 FTEs that are supported with Title V federal funds and an additional 71.5 funded either through state general funds or appropriated special funds. As part of this request, the state is seeking technical assistance in designing an efficient system for tracking personnel hours and activities performed in the following maternal and child health areas: Pregnant Women, Mothers, and Infants, Children and Adolescents, and Children with Special Health Care Needs. Technical assistance would include identification of best practices, exploration of options for creating a system, development, implementation, and testing/evaluation of the system.

A second topic for technical assistance is the needs assessment. Currently, we are in the early stages of the 2010 Needs Assessment and have convened an internal working group which will expand in the near future. We have begun using the CAST V instrument in our initial environmental scans. We are investigating several avenues of needs assessment related technical assistance - these include assistance through either an MCH related consulting firm or through the Centers for Disease Control and Prevention (which may have such assistance available later in the year). At this time, a formal proposal for technical assistance has not been completed, however we anticipate such a request may be developed and submitted by December 2008. The primary purpose of the assistance would likely be to assist the State's stakeholders in a process of prioritization and ensuring priorities and selected indicators are not duplicative of existing/required measures. //2009//

/2010/ In 2009, Delaware started a process to support an "umbrella organization" that

would be responsible for providing funding, capacity building assistance, information and referral and professional development opportunities to organizations that service families with children with special health care needs in Delaware. This effort was conceived, in part, in recognition of the inefficiencies which result from state efforts to assist smaller community organizations. A key informant interview process resulted in some general consensus on themes that should be addressed. These included:

1. Fragmentation
- multiple funding streams
- lack of coordination among State agencies

2. Duplication of Effort at the Community Organization Level
- disconnect between agency mission and scope
- the need for an authentic connection between an agency and a family vs. passing off families to others
- organizations knowing what each other does
- appropriate referral patterns (could also be considered as a part of capacity)

3. Case Management/Care Coordination
- need to identify organizations that offer this
- parents as coordinators

4. A greater understanding of the complexities of information needs
- as the child ages/develops, parents need to know how to ask the right questions
- co-existing conditions
- overall family needs

A work group consisting of the key informants convened twice to date and has decided to proceed with development of a request for proposals with the intention of funding an organization that would be willing and able to take on the roles of funding, technical assistance, dissemination of information and referral and professional development.

Informational meetings are planned throughout the state in late summer 2010.

We are seeking technical assistance in developing such an organization and would be interested in learning more about a successful model from another state.

//2010//

V. Budget Narrative

A. Expenditures

/2009/ Title V Maternal and Child Health Block Grant funding has historically funded staff positions within the Division of Public Health's clinic-based MCH programs, including Smart Start, Kids Kare, Child Development Watch and the Oral Health program. As noted in the Technical Assistance section, Delaware is in need of an efficient tracking mechanism to report staff time and effort across programs and populations. The Delaware system that is used for financial reporting is scheduled to be replaced within the next two years and this presents a good opportunity to address this need.

An initial factor in fluctuations that may be apparent is that two years ago (for the FFY 2007 Block Grant Application), MCH staff reviewed staffing patterns and assigned positions' effort according to level of service and population. This resulted in some variation in the amounts reported by level of service and population from year to year over the time period this methodology was applied and adopted.

A second factor contributing to fluctuations from year to year across service types and populations served is an increase in state spending for MCH programs. In 2006, the State significantly increased its funding, primarily due to a 2005 task force report on infant mortality in Delaware. Since 2006, the state funds allocated to infant mortality has increased each year. Hence, there has been corresponding increases in the amount of funding reported targeted to pregnant women and infants. Over this same time period, the Division of Public Health has reduced some of its funding targeted to teen pregnancy prevention programs. So fluctuations/decreases in the amount budgeted/expended for children 1-22 are apparent. It should be noted, however, that Delaware does not include School-Based Health Center funding in the amount reported in the MCH-State Partnership. This annual budget from state funds is over $6 million per year. Additionally, some of the funding that has been traditionally reported for the Kids Kare program for children 1-22, has been reallocated to Children with Special Health Care Needs in the budgeted funds/expenditures noted. This is not an actual shift in funds, but a recognition that Kids Kare also serves Children with Special Health Care Needs, as well as other children.

Form 3 reports 2007 funds were expended as budgeted, a total of $12,458,136 in State and Federal partnership funds. The decrease in other funds from 2007 to 2008 was a result of the State no longer including Newborn Screening Revenue as part of the State Maintenance of Effort and shifting to Infant Mortality state funds. Form 4 reports the amount budgeted for infants increased significantly from 2007 to 2009. This is mainly an effect of state infant mortality funds and the result of reallocating staff salaries in the Smart Start and Kids Kare programs to this population.

Form 5, shows a decrease in the amount allocated to Direct Health Care Services from 2007 to 2009. This is mainly attributable to a review of program activities and allocating staff time accordingly, a recognition that some direct services were enabling services or population based services. //2009//

/2010/ During Federal Fiscal Year 2009, Delaware included several new initiatives that provided small amounts of funding. The first is an effort to support family organizations that focus on children with special health care needs. A consultant was hired to conduct key information interviews and issue a report on next steps based on the findings ($36,000). The second effort supported an administrative position to work with the Special Needs Alert Program's database. This program provides emergency responders with information about children with special needs ($20,000). A third initiative was a joint effort between Disease Prevention and Health Promotion and MCH. This effort ($20,000) provides contractual funds to the University of Delaware's Cooperative Extension to

develop an education module around nutrition and obesity prevention in early childhood. When completed, this module will be part of an educational curriculum offered to early childhood care providers to meet new licensing requirements in the State. A fourth initiative was a pilot breastfeeding project ($19,000) in the State's Smart Start program. This initiative seeks to increase breastfeeding rates through enhanced education and support. The breastfeeding project also offered a statewide conference in June 2009 targeted to health professionals.

As in previous years, a very large portion of MCH funds are dedicated to existing staff positions in four program areas: Smart Start, Kids Kare, Child Development Watch and Oral Health.

//2010//

B. Budget

/2009/ The maintenance of effort remains the same with the State of Delaware continuing to provide an an amount that exceeds the baseline maintenance of effort (MOE) established in Federal Fiscal Year (FFY) 1989. The baseline MOE was $5,679,738. For FFY 2009, the State MOE is $10,048,693. This amount consists of salaries and fringe for 73.5 staff (administrative, KIDS Kare, Child Development Watch, the Dental Program and Smart Start) totaling $5,580,198 and funds budgeted for the State's Infant Mortality program totaling $4,460,500.

The budget amount for federal funds includes an estimated FFY 2009 allocation of $1,962,811 (based on level funding and the FFY 2008 estimated allocation) and an estimated $485,507 remaining in FFY 2008 funds on October 1, 2008. These remaining funds are mainly due to staff vacancies.

Of the total $2,448,318 federal dollars that are budgeted, $1,690,998 are for salaries and fringe for 26.4 FTEs (Smart Start, Kids Kare, Child Development Watch, Oral Health and administrative staff). The balance of the federal portion of the budget includes: $10,000 for travel expenses, which include the annual MCH Partnership and AMCHP meetings, as well as additional MCH training related opportunities; $3,000 for supplies and materials (pamphlets, brochures and other media for programs); a required $188,615 in indirect cost (calculated 16.47% of federal supported salaries); $56,576 for other required expenses (state computer charges/federal staff, postage, phone lines, malpractice insurance, copies); and a state audit fee of $3,296. The remaining funds will be used for several ongoing and new initiatives:

$30,000 -- renewal of a contract with the Coordinating Council for Children with Disabilities. This contract provides education and mentoring for Council members, professional management of the Council (including support functions), broadening the advisory role of the Council (through the facilitation of communication of issues, grants, projects, etc. and collaboration with private/public agencies with goals consistent with the CSHCN program) and research activities.

$20,000 -- These funds will support a new initiative, sponsored by the Children with Special Health Care Needs Program to distribute the new edition of Bright Futures to field staff throughout the state. A series of forums will be held to learn about the types of screening (developmental and physical health-related) that are being carried out throughout the state and to provide educational opportunities to learn about best practices in screening.

$10,000 -- These funds will support a planning process to develop services for the prevention of obesity.

$20,000 -- These will support a planning process to enhance the state's coordination of services related to Autism Spectrum Disorders.

$29,000 -- These funds will support the Special Needs Alert Program (SNAP) for Children with Special Health Care Needs. The purpose of the program is to identify a special needs child when placing a 911 call. Parents/guardians enroll children in the Special Needs Alert Program (SNAP), by completing the following forms:

- The Enrollment Form
- The Home Visit Information (or Home Information) Form
- The Emergency Information Form (This must be completed and signed by the child's physician. This is the form developed by the American Academy of Pediatrics.
- The Consent Form

To better serve children with special health care needs in Delaware once again and encourage growth of the SNAP program we will hire an Administrative Specialist II for 24 hours (three days) per week through a contract with the Easter Seals of Delaware.

$19,000 to enhance a pilot program, "Best Start." This demonstration project is funded by the Division of Public Health (DPH) Women, Infants and Children (WIC) Program Office and staffed by Milford Public Health Unit staff. Staffing includes the Nursing Supervisor, two Registered Nurses, and a Senior Medical Social Work Consultant. One nurse is an ILBC certified lactation consultant.

The project began on May 1, 2008 with the receipt of the WIC funded breastfeeding supplies available for use by the Smart Start "Best Start" mothers. The target population for the project is 35 prenatal clients interested in breastfeeding their infant for minimum of 6 months. The goal is to achieve 80% of mothers continuing to breastfeed their infants at 6 months. The MCH funds will support the purchase of educational materials for staff and clients, an opportunity for a RN to attend a lactation consultant course and a Breastfeeding Conference to be held in Spring, 2009. //2009//

/2010/ The Delaware Maternal and Child Health program recognizes that staff vacancies and mandatory hiring freezes are straining our capacity to effectively plan, develop and monitor some of our programmatic efforts and initiatives. To ease this strain, the MCH program plans to contract services for a number of needs, including the vacant Children with Special Health Care Needs Director position, epidemiology and consulting services and staff support within our Center for Family Health Research/Infant Mortality initiatives.

The planned budget for Federal Fiscal Year 2010 includes 27.9 FTE's. 27.4 of these FTEs are existing
positions. An additional 0.5 FTE, a Public Health Treatment Administrator, will be designated as the Oral Health Program Administrator and be responsible for the development, implementation and evaluation of all aspects of the state-wide oral health grant activities and programs under the general supervision of the State Dental Director. This includes responsibility for coordination and management of grant proposal and performance measures, contract development and administration for grant funded activities. The incumbent will be responsible for educating and informing other agency staff, community organizations, health care providers and the general public about current and emergent oral health issues and will act as the clinical dental resource person within the DPH oral health program. Additionally, the incumbent will provide technical assistance and training ensuring compliance to rules and regulations. Additional responsibilities include the oversight and provision of preventive and educational state-wide programs and activities.

We are planning to issue an RFP to fund an umbrella organization to serve community-based agencies throughout Delaware that serve families with Children with Special Health Care Needs. The total amount to be awarded is still to be determined.

We plan to continue support for the Special Needs Alert Program and to conduct a needs assessment related to childhood injury prevention. We will investigate increasing support for our Best Start Breastfeeding program pending findings from our pilot program. Additionally we will continue our partnership with the Family 2 Family Program and the Coordinating Council for Children with Disabilities. Both of these organizations provide mentoring opportunities to families with children with special needs. Our plans also include an evaluation of our Child Development Watch Program.

//2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.